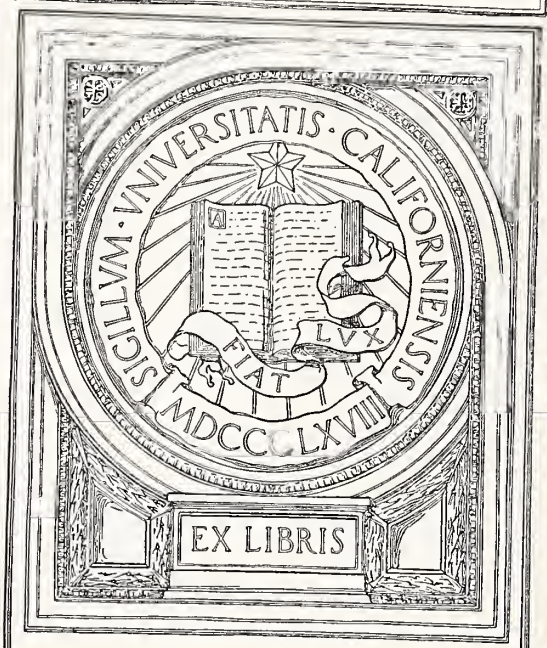
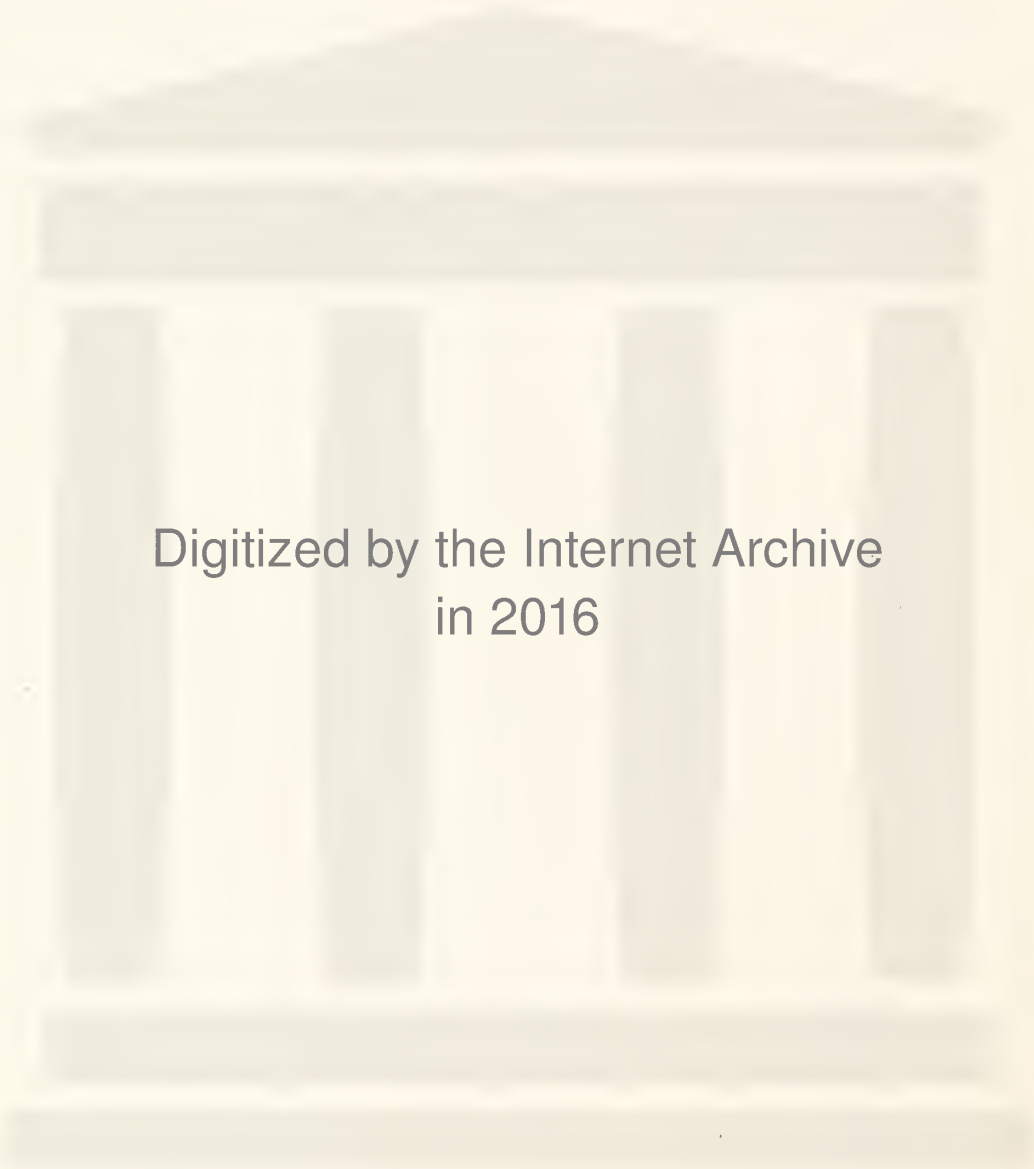
UNIVERSITY OF CALIFORNIA
MEDICAL CENTER LIBRARY
SAN FRANCISCO




Digitized by the Internet Archive
in 2016

https://archive.org/details/connecticutstate16unse

Vol. XVI • JANUARY 1952 • No. 1

Connecticut State Medical Journal

U. C. MEDICAL LIBRARY

JAN 17 1952

San Francisco, 22

160th ANNUAL MEETING

Bulkeley High School, Hartford

April 29, 30 and May 1, 1952



THE CONNECTICUT STATE MEDICAL SOCIETY

WE PRESCRIBE

ACCEPTED COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION AMERICAN MEDICAL ASSOCIATION

Rx

-KEEPING UP WITH THE JONESES!



here are busy Joneses right in your neighborhood, and busy Jones machines in literally thousands of other doctors' offices, helping those doctors keep up with patient demand for complete medical service, helping those doctors keep up with the highest standards for accurate diagnosis and treatment, helping those doctors keep up with the latest medical techniques.

Still greater success and prestige for you too will accompany investment in this additional service to your patients, for there is no basal machine so accurate as a Jones, and nothing so revealing as an accurate B.M.R.

Tests are made conveniently, accurately, and quickly. (1) The Jones oxygen gauge is based on Charles' and Boyles' laws of pressure and enables you to measure conveniently and automatically one liter of oxygen corrected for all conditions of temperature and pressure without any figuring. (2) The Jones machine is accepted by the Council of Physical Medicine of the A.M.A. to be mechanically accurate to 1%. The protractor, matched over the shape of the graph, shows up any accidental oversight in routine of technique. Any discrepancies such as from nose or mouth leaks or other disturbances are immediately detected. (3) The metal slide rule eliminates calculation completely. In just two moves you quickly read the Basal Metabolic Rate of your patient.

The above are just three of the outstanding features which contribute to the leadership of

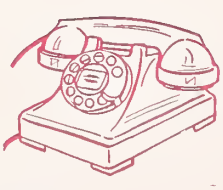
THE JONES BASAL METABOLISM MACHINE

The Jones machine is dependable and a beauty. Write or phone us for literature or a demonstration.



PROFESSIONAL EQUIPMENT CO.

36 HOWE ST. NEW HAVEN



New Haven 7-2138, Norwich 9-0863, Hartford 2-5259

Table of Contents : January 1952

The Physician's Responsibility in Civil Defense
William L. Wilson, Colonel, Medical Corps, U. S. Army 3

The Value of Influenza Virus Vaccination in Industry
C. F. Yeager, M.D., Remington Arms Co., Bridgeport 7

Recurrent Umbilical and Low Midline Abdominal Incisional Hernias in Adipose Women
Charles L. Larkin, M.D., Waterbury 9

Political Medicine
Congressman James T. Patterson 15

EDITORIALS

It Can Be Done 18
Psychiatry in General Hospitals 18
Professional Relationships 19
Society Loses Oldest Living President 19
Catastrophic Illness Insurance for Members 20
Your State Medical Journal 20

DEPARTMENTS

Progress in Clinical Medicine
Iron Metabolism in Hemosiderosis and Hemochromatosis
E. Clair Rankin, M.D., Hartford 21
The President's Page 25
The Secretary's Office 26
The Historian's Note Book
The Story of Subcutaneous Medication
George Blumer, M.D., San Marino, California 29
Military Affairs 41
News From Washington 45
Public Relations 48
From Our Exchanges 52
Woman's Auxiliary 56
Special Notices 62
Letters to the Editor 64
News From County Associations 66
Book Reviews 68

MISCELLANEOUS

L A Calling
AMA Interim Session 31
Relations of Physicians and Hospitals 35
The Doctor's Office 50

80376

WAS Your ACCEPTANCE OF CMS FOR YOURSELF AND YOUR FAMILY

IN THIS BATCH* OF MAIL?



TAKE ADVANTAGE OF THIS OFFERING OF CMS MEMBERSHIP TO ALL BLUE CROSS DIRECT-PAY MEMBERS

*Nearly 5000 applications, covering 11,500 Connecticut people, were received during the first month of this offering!

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI JANUARY, 1952 No. 1

THE PHYSICIAN'S RESPONSIBILITY IN CIVIL DEFENSE

WILLIAM L. WILSON, *Colonel, Medical Corps, U. S. Army*

The Author. *Assistant Administrator for Health and Welfare, Federal Civil Defense Administration, Washington 25, D. C.*

WHEREVER one turns, anxiety exists over the lack of reasonable security against threats of enemy attacks. It cannot be asserted positively whether or not such a fear may be justified. Our cities might be subjected to atomic or other modern attacks, with or without a warning to the population. The potentialities are known to be present. What is sure, however, is that people have always accepted equally great challenges to their survival in the past. They have sought assurances of that survival with resultant relative success in their efforts.

Now as in the past, a people have a right to demand, and must have, proper leadership in their efforts at survival. Despite the fact that there is nothing new in this situation, this is a good time for a brief discussion of the physician's responsibilities in the efforts of the people. The reason it is a good time is that we are at a critical point in this country when we must decide whether or not we intend to insure our future existence. The physician is one of the most prominent citizens of every community who will lead in the decision made by each community upon the answer to this important question.

Civil defense is inherent, is essential to national survival if the United States should be attacked by a powerful enemy. Although each community may claim the privilege of determining whether it intends to survive, the fact remains that national survival is unlikely without individual community survival.

Civil defense is an activity required of every community, wherever the physician practices. It is an activity necessary to guarantee to all of the Armed Services that a stable community for all family life will be maintained, as will also that productive home support so necessary to military operations at home or abroad.

No informed person in this modern existence could fail to appreciate three facts, the first of which is the sheer futility of armed might without successful home defense. A second fact is that there would be equal futility in failing to provide for full military defense. The third and most vital fact which appears to be overlooked by many is that nation must balance its military and civil defense in order to be likely to survive.

It is almost staggering to recall that United States Civil Defense is now just eight months old, as we realize that the Federal Civil Defense Act of 1950* reiterates the age-old truths just mentioned. That law defines "civil defense" in a manner indicating the priorities to be given to minimizing the effects upon the civilian population caused or which would be caused by an attack upon the United States, to dealing with immediate emergency conditions which would be created by such an attack, and to repairing or restoring vital utilities and facilities destroyed or damaged by any such attack. A physician should and does sense immediately his potentially essential part in the survival of the Nation if attacked.

It would be a waste of your time to listen further if it were necessary to justify civil defense in the balancing of the equation of national survival. The President had previously justified civil defense when the Congress of the United States enacted the Civil Defense Act of 1950 earlier this year. Now we should pause and evaluate our progress since that time.

*Public Law 920, 81st Congress, Second Session—January 12, 1951.

Presented at the 26th Connecticut Clinical Congress, New Haven, September 12, 1951

A need for civil defense has been greater or less for many nations from time to time. While others were being subjected to enemy attacks, civilians of the United States have been fortunate enough to escape attack for so long a time, that it is understandable when an unrealistic attitude arises here or there with reference to civil defense. But persistent and generalized neglect is another matter and one not to be condoned.

With this thought in mind, is it any wonder that those working at civil defense find it difficult to understand cynical criticism of our very new civil defense plans, or broad and unwarranted charges that the present status of civil defense in the United States, after only eight months of existence, is due to an unrealistic approach to the civil defense problems? I believe we must consider the facts.

Human life and productive skill cannot be replaced readily. This is a matter of major importance to the United States, where the numbers of our people are limited, where their skills increase and capabilities are highly specialized only after long, carefully directed training, and where they are concentrated into densely populated areas of unbelievable vulnerability to attacks. Another nation of more people, less skilled, carries less risk to its people than we do, while at the same time it can create a menace to us. As critical as material damage to our cities could be, under the circumtsances, the truly precious factors which we must preserve are life, health and effective production. The immediate, deepest and most understandable concern of all of us in the presence of enemy attack would be for the health and safety of our wives, children, loved ones, relatives and close friends. How long would our Armed Forces continue to fight if individual members who have gone out to face the enemy cannot be reasonably sure that loved ones at home are safe? Support of our Armed Forces and the maintenance of full civilian industrial support of a future war effort therefore depends upon our ability to preserve maximum physical and mental health of all of our civilians, or to restore it where interrupted. That is why the physician is the bulwark of this Nation, why the physician has been and must continue to be a leader in every community civil defense preparation for survival, a hazardous survival from any damage an enemy could devise or direct against us.

Today there are some, and even prominent people, who say that civil defense will be unnecessary if we develop strong Armed Forces. We should tremble at any single time such an opinion is expressed in our country. That is the same type of fallacious and undermining reasoning found before and during the early days of World War II, which led the German civilians to their destruction. Furthermore, the far-flung military might of Japan was fully expected to preclude attacks upon the Japanese homeland or its civilians.

The British authorities, government, and people, in the period 1935 to 1940, anticipated and assured reasonable civil defense preparation five years in advance of enemy attacks upon the civilian communities of the United Kingdom. They did that in addition to supporting the military preparations being made. Germany is not now a nation; Japan's national independence vanished; the United Kingdom survived!

In spite of military defense, the force of an enemy attack can break through. The damage done would require community attention, the major portion of which would be local civil defense. Yet, there are antagonistic critics of civil defense efforts in the United States who not only would do nothing themselves to prepare for the damage likely to result from atomic and incendiary attacks. They would discourage other more loyal citizens from being ready and able to cope with such problems.

The present prospect of hostile attack upon the United States is greater than at any time in a century and a half. Our military authorities, of unquestioned competence, tell us without equivocation that our communities can be attacked today. Certainly such an attitude has been no habit with them. General Hoyt Vandenberg, Chief of Staff of the Air Force, has stated clearly that at least 70 per cent of attacking bombers could get through our best military defenses—so we are vulnerable. We do face what Germany, Japan, and the United Kingdom faced in 1939 and 1940. Unfortunately, we are now more like Germany and Japan in 1940 than like the United Kingdom.

Physicians may have pardonable pride in their past foresight leading to medical preparations for atomic attacks, preceding the nonmedical civil defense preparations of others in this country. Eleven years ago it was civilian physicians who first foresaw the need for a national medical organization to care for our own civilians if subjected to enemy attack. Nearly five years ago, when others were not actively engaged in such matters, the present Surgeon General of the Army supported a proposal for

development of national methods for integrating military with civilian administration of health services of the Nation for war, if it should come. Four years ago, the medical profession established the Council on National Emergency Medical Service of the American Medical Association leading to prompt, earnest development by the profession of methods by which physicians could support the Government in a national emergency. Soon after that, the Public Health Service and State health authorities undertook the problem with equal confidence and ability. More recently physicians, grouped or banded together in practice for great good, have aligned thousands of citizens, or prepared them for aiding, in civil defense operations. As an example, physicians of one of our church denominations have initiated an organization and the training of its whole membership, while the Medical Correctional Association, through the American Prison Association, has stimulated a civil defense program for many thousands of prisoners. We need to go no further to substantiate medical leadership of the past in developing community civil defense.

The way of the future is open to us now, but how long will we have the privilege? The future of civil defense depends upon every citizen. What each citizen does, or even more important does not do, and that promptly, will influence our success or failure in survival.

Immeasurable future contributions of time, thought and effort, and many and great additional sacrifices by the medical profession will be required, if physicians are to maintain necessary levels of health in the population they have always served so faithfully. It is readily understandable that the questions most physicians want answered now involve details as to the manner in which they may serve, and when and where. These are questions which will not be answered in detail at this time by one individual, one governmental agency, or one group. They are questions the answer to which influence and are influenced by every family and every home. The medical profession cannot solve the problems alone. Nevertheless, physicians can, and their leadership must, participate in the solutions while and as they are being developed, in order to maintain to the maximum practicable degree the health of the family and the significance of the home. Community physical and mental health, along with a desirable level of moral standards depend upon this, the public's confidence depends upon it, and desirable social effects of our preparation for civil defense, as well as any operations which might be required in the future, depend upon it.

There can be no simple formula, one page direction, or even one pamphlet which will provide an easy road. We of the Federal Civil Defense Administration are proceeding in a systematic manner, with a purpose to design, develop, and aid in establishing a nationwide emergency health and welfare service for civil defense second to none. Do not be misled by statements to the contrary. It is a large order, a grand challenge. We can and will provide the guidance to the States. We can coordinate their planning and activities by assuring mutual confidence, by frequent consultation with State authorities. We can estimate the material requirements for Federal assistance to the States. Not only can we do all of this. We are doing it! But no control from Washington and no national units will achieve civil defense. The local community must do that.

How should the physician fit into this program reported in such broad and general terms? This will continue to be done in two ways. Professional guidance should come to you from your medical associations' national and State offices. We will work with the American Medical Association as we are doing with the other national health and welfare oranizations. Operational guidance for the local organization should come to your local medical organizations and individual physicians from the State and local directors of Civil Defense, and from their health service directors.

Operational details have no place in this brief discussion, but you know that the physician has a dual obligation after any enemy attack. On the one hand, he must maintain essential service to the sick usually present in the community, who would require medical aid irrespective of attack. In addition, the physician has a vital civil defense role in support of the first aid personnel, the first aid stations, the hospitals and casualty convalescent institutions. Where the physician wants and needs guidance on these duties, it will be furnished through civil defense offices.

The physician, with rightfully expected guidance, must volunteer and contribute his own participation and not await recruitment. He must insist upon establishment of a sound local civil defense system, under control of suitable local authorities. These authorities must inform and teach the physician those non professional matters peculiar to civil defense with which he may be unfamiliar.

Once we understand our respective missions, all of us must follow a uniform program in our development of plans. It is true that the uniformity must follow a leadership of national origin. The Federal Civil Defense Administration rightfully may be expected to suggest organizational structure and staffing patterns; objectives and their priorities; material means and their proper sources of origin; operational programs; training means and measures in technical, administrative, managerial and functional aspects of all programs; uniform standards of measurement of performance; but above all, an integrated, multilateral system of controls developed through a consultative participation by physicians. To achieve all of this, patience, tolerance, and friendly joint exploration of all of our problems will be esssential. In this most difficult phase of all, namely the preparation phase for civil defense, we cannot do without a sense of humor and a penchant for endless work. That work must be contributed by the profession, by the Federal, State and local governments, and by the public.

Physicians should review the possible circumstances and problems, and the procedures and methods most likely to assure effective, feasible, economical appplication of medical resources that may be available.

The physician first would need to become a teacher of preventive as well as therapeutic measures by which laymen, under medical training and supervision, will avert, minimize, or repair human damage. Physicians have hardly begun to assume their responsibilities in this field. At the same time they must continue their healing of the normally occurring sick and injured where these are critical in nature, rather than furnishing our luxury services. Physicians must continue and expand also the public health services, by calling in the aid and support of every conceivable related profession, art, or science, all then jointly teaching citizens their respective parts in achieving successful public health. A third great program of teaching will be that involved in the organization, training, supervision, and leadership of countless thousands of lay as well as professional personnel of the emergency medical or casualty and hospital services. A fourth objective would be to teach our civilian physicians about the medical and health problems of dislodged, homeless, and needy victims of direct enemy attacks, as well as of thousands who might be mass evacuees. It is in this field more than the others perhaps that physicians serving rural areas may find their greatest opportunities for service. A fifth endeavour, markedly increased over that of peacetime would be development of training for rehabilitation services for those thousands of physical and mental casualties we can anticipate following attacks. Finally, in the health field, the physician must be prepared to teach the defenses against psychological warfare. More than any other group, physicians can and must achieve this. Health education, mental hygiene, panic or other mass reaction controls must be a daily duty of physicians, and all need to be undertaken in an intelligent manner.

To achieve these six important missions I have outlined will require admission by the physician that he must proceed along four lines of attack:

He must advance his own knowledge consistently.

He must impart his acquired knowledge to his professional allies and to the people, in understandable form.

He must conduct educational programs which will prepare the people against all physical, mental, and moral hazards created by enemy attacks, revising them as newer knowledge dictates.

He must apply every available material, psychological, spiritual or moral resource to maintain physical and mental health. This means that many physicians will be compelled to recall, or learn for the first time, the great significance of the human environment as related to personal health. He must exploit to a maximum degree such fundamental human welfare resources as water, food, clothing, shelter, warmth, individual and family security, home life—health essentials we take for granted so readily in peacetime as to make us overlook their importance in preparing for war.

The physician, more than any other person, is selected for these duties by his normal community responsibility and position. He comes into direct contact with more individuals and families, with more homes, from birth to death, than does one of any other profession. He can teach as he practices public health and prevention in the health departments, and as he heals the sick and injured.

By now you must realize what civil defense means. Every citizen becomes a soldier, every physician becomes a fighter. It is conceivable that every volunteer will become a veteran in the survival effort. The success of our community effort will vary directly according to the extent we are willing to

fight for our ideals, our principles, our existence. Surely it is worth the added responsibility.

Your community, your existence, your family cannot survive a forceful enemy attack of atomic, biological, chemical, psychological or any other type, if you do not have an opportunity to fight for them. You have a right to demand and obtain that opportunity.

When each physician will have participated wholesomely and cheerfully in a manner somewhat similar to all that we have just considered, then, and perhaps only then, can he realize in the words of Ruskin, his true goals of preserving the American home:

"This is the true nature of home—it is the place of Peace; the shelter, not only from all injury, but from all terror, doubt, and division."

Civil defense depends upon you, the physician!

THE VALUE OF INFLUENZA VIRUS VACCINATION IN INDUSTRY

C. F. Yeager, M.D., *Remington Arms Co., Inc., Bridgeport*

Influenza in Connecticut during late February and March 1951 was prevalent in many areas. Although there was no general prevalence in the United States the Influenza Study Program of the Public Health Service of the United States reported outbreaks in New England, New York, Pennsylvania, Ohio, Illinois, the West Coast, and Texas. According to a report on the third year of operation of the Influenza Information Center at the National Institute of Health, the disease was mild and nearly all outbreaks were identified as the A-prime type.

An outbreak of respiratory infection resembling influenza was observed at the Remington Arms Co., Inc. in Bridgeport, Connecticut, in late February and March, 1951 among the 2,799 employes. A total of 350 cases of respiratory diseases occurred between February 20 and March 31, 1951 and were carefully studied in an attempt to evaluate the possible efficacy of influenza virus vaccine in preventing influenza. In this series of cases all employes lost time in excess of two consecutive working days. For example, an employe who worked on Wednesday but did not work the remainder of the forty-hour week due to a respiratory infection and returned to work the following Monday was not included in this report. Following an analysis of the 350 cases, it was concluded that 198 had clinical influenza. Reports from other industries in Bridgeport during this same period showed an unusually high incidence of absenteeism due to influenza. Absences in some industries ran as high as 20 to 25 per cent.

For the past five years, employes at the Remington Arms Co., Inc. in Bridgeport, Connecticut, have been given the opportunity of receiving immunizing doses of influenza virus vaccine. The injections were always given in November and December in the plant hospital strictly on a voluntary basis. In November and December 1950, a total of 555 employes were vaccinated. In late February and March 1951, an additional 292 employes requested and were given the vaccine. This totaled 847 vaccinated, representing 30.26 per cent of all employes at the Bridgeport plant. It is safe to state that the request for the additional vaccinations was due to the publicity in the local newspapers calling attention to outbreaks of influenza in Bridgeport and other areas. The influenza vaccine administered contained a mixture of types A and B. The percentage of each of the strains used is as follows: PR8 22.22 per cent, FM-1 22.22 per cent, Cuppett 22.22 per cent, and Lee 33.33 per cent.

Not until February and March 1951 was there an opportunity to study the effects of immunizing the employes with influenza virus vaccine. It was recognized before the analysis was begun that the method used in obtaining the results would be open to question by any scientific investigator in this field, and apologies are made for our limitations and shortcomings. To the writer's knowledge, an isolated virus was not obtained in any of the cases studied.

The industrial physician has excellent opportunities to study the effects of preventive medicine. Any significant mass deviation from the normal

Table No. 1

Influenza Survey—February and March, 1951

Shows method used by examining physician in recording information deemed necessary for this type of survey. Three sources of information were available: (a) Physician's statement on insurance forms, (b) Visiting nurse contact, (c) Direct questioning of employe in plant hospital at the time of employe's return to work.

NAMES OF EMPLOYES	DATE OF ONSET	DAYS LOST	MAX. TEMP.	WEAKNESS	THROAT	CHILLS	SWEATING	JOINT PAINS	COUGH	HEADACHE	VERTIGO	DYSENTERY	DIAGNOSIS	FLU VACCINE	DATE RECEIVED	MEDICATION RECEIVED
Names of	3/13	6	102	2+	2+	2+	2+	2+	0	2+	2+	0	Flu	No		Penicillin
Employes	3/10	8	102	2+	0	2+	2+	2+	0	2+	2+	2+	Flu	No		Penicillin
Omitted	3/8	10	?	0	3+	0	0	2+	0	0	2+	0	Grippe	No		Sulfa drug
	3/12	6	101	2+	0	3+	3+	3+	0	3+	2+	0	Flu	Yes	11/13/50	Sulfa and
															3/8/51	Penicillin
	3/9	9	101	0	3+	2+	2+	3+	0	3+	2+	0	Flu	Yes	11/16/50	Capsules?
	3/7	11	102	2+	0	2+	2+	3+	3+	3+	2+	0	Flu	No		Sulfa and Penicillin
	3/14	4	99[2]	2+	2+	2+	2+	2+	0	2+	0	0	Cold	No		Sulfa drug
	3/12	5	101[6]	2+	+	2+	2+	3+	2+	3+	0	0	Flu	No		Penicillin
	3/10	9	?	2+	+	2+	+	3+	3+	3+	0	0	Flu	No		Penicillin
	3/14	4	?	0	0	0	0	2+	2+	2+	0	0	Flu	No		Streptomycin
	3/12	6	99[4]	0	0	2+	2+	2+	2+	2+	0	0	Flu	No		Sulfa drug
	3/9	9	102	0	3+	0	3+	3+	3+	3+	0	0	Flu	No		Penicillin
	3/9	9	101	2+	2+	2+	2+	2+	0	3+	0	0	Flu	No		Penicillin
	3/9	9	?	0	0	2+	0	0	2+	2+	0	0	Flu	No		Capsules?
	3/13	3	100	1+	1+	0	2+	2+	0	1+	0	0	Cold	No		Penicillin
	3/9	9	101	2+	2+	2+	2+	3+	2+	3+	2+	0	Flu	No		Capsules?
	3/2	17	103	3+	3+	4+	4+	4+	+	4+	2+	0	Flu	No		Penicillin
	3/10	9	104	3+	3+	3+	3+	3+	0	3+	3+	0	Flu Quincy Throat	No		Penicillin
	3/14	5	101	2+	3+	3+	3+	3+	0	3+	2+	0	Flu	Yes	11/16/50	Sulfa drug
	3/14	3	101	2+	2+	2+	1+	1+	2+	2+	0	0	Flu	No		White pills?

health would be called to the industrial physician's attention immediately. Furthermore, industrial managements have found that it is good business to have preventive medical programs. Industry is dependent upon average attendance of its employes with allowances made for seasonal increases in absenteeism resulting from illness. Any large scale epidemic would not only cut into the profits of the industry, but it might conceivably bankrupt itself.

Most of all of the basic information which was necessary in the survey of the 350 cases was obtained in the plant hospital when the employe returned to work following his illness. Each employe was carefully interviewed and the information given by the employe when questioned specifically about his illness was charted. See Table No. 1. In some instances leading questions had to be asked in order to properly evaluate the case. Many of the employes were seen at home during their illness by the plant visiting nurse, and the information she obtained was most helpful in the survey. Of definite value also was the family physicians' diagnoses written on insurance claims.

Of the 1952 unvaccinated there were 183 cases of clinical influenza while only 15 cases appeared in the 847 vaccinated, or 9.4 per cent incidence in the unvaccinated group as compared with 1.77 per cent in the vaccinated group. The average number of days lost was 8.0 days in the vaccinated group and 8.2 days in the control group. See Table No. 2.

Table No. 2

Average number of employes working from November 1950 to March 1951	2,799
Total number employes given vaccine	847
Total number employes unvaccinated	1,952
Number of cases—vaccinated group	15
Incidence—vaccinated group	1.77%
Number of cases—unvaccinated group	183
Incidence—unvaccinated group	9.4%

The results obtained are almost identical with those of Francis, Salk, and Brace; who described an epidemic of influenza B under controlled conditions and reported an incidence of 9.91 per cent infection in an unvaccinated group while 1.15 per cent of the vaccinated group showed evidence of infection.

CONCLUSIONS

1. An outbreak of respiratory infection resembling clinical influenza was observed in late February and March 1951 among workers at the Remington Arms Co., Inc., Bridgeport, Connecticut. Reports from other industries in Bridgeport indicated similar observations and there was an exceptionally high incidence of absenteeism.

2. If it can be presumed, in the absence of laboratory diagnosis designating the specific virus, that the outbreak was due to the A-prime influenza virus as was found in other communities during this period, the results obtained in this series of cases strongly indicate that the subcutaneous injection of 1 cc. Influenza Virus Vaccine containing 22.22 per cent FM-1 did significantly reduce the incidence and exert a striking protective effect against the disease.

Appreciation is expressed for the help and cooperation given by the Nursing Staff and Dr. T. J. Impellitteri of the Remington Arms Co., Inc. in the preparation of this report.

RECURRENT UMBILICAL AND LOW MIDLINE ABDOMINAL INCISIONAL HERNIAS IN ADIPOSE WOMEN

CHARLES L. LARKIN, M.D., *Waterbury*

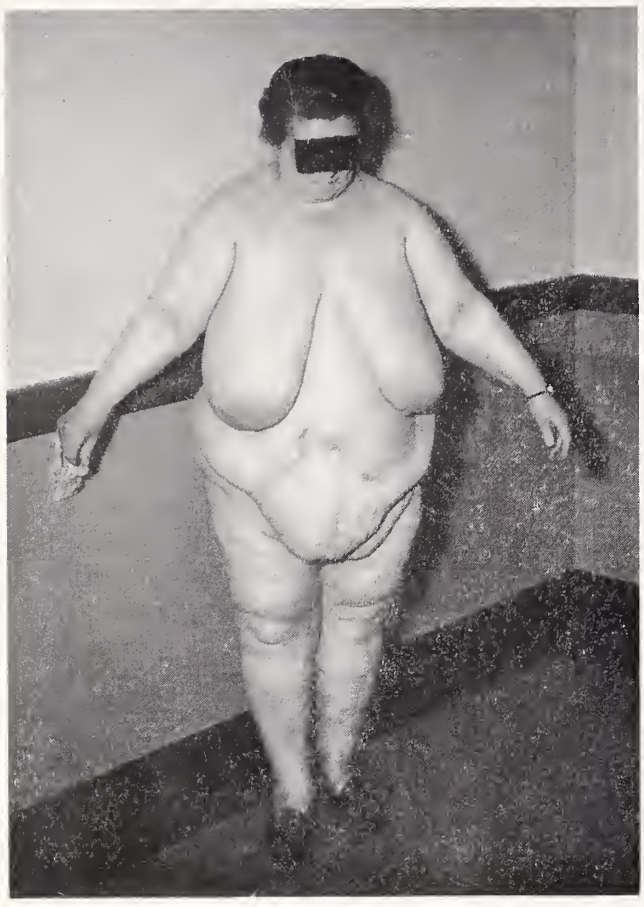
The Author. *Attending Gynecologist, Waterbury Hospital, St. Mary's Hospital, Waterbury*

THERE are thousands of obese women suffering from recurrent umbilical or lower midline incisional hernias, or both, who are forced to lead lives of semi-invalids because they have not received the benefits of proper surgery and therapy. Most surgical books casually refer to recurrent umbilical and low midline abdominal postoperative hernias, advocating an incision over the hernia, dissecting out the sac, opening it, reducing the contents, removing the excess sac and closing the wound in layers. The impression given is that the hernias are cured if the advised technique is followed. Unfortunately many of these hernias, especially in obese women, will recur even after a half dozen or more standard operations have been performed. These standard operations make an attempt to eliminate some of the factors which contribute to the recurrences, but none of them provide for the removal of the basic trouble which is, as Cave[1] says, "due to excessive intra-abdominal tension caused by intra-abdominal fat."

Some of these women have generalized obesity but others suffer from adipose pituitary dystrophy. Most of them have had one or more children. Many suffer from hypothyroidism and some from secondary anemia. Their arteriovenous circulations are invariably sluggish because of myocardial fatty infiltration. They all have deep subcutaneous fat and each and every one of them has an abdominal panniculus that hangs well down on their thighs. All have thick bulky omentums, and are quite inactive because of their obesity and because of the recurrent hernias that cannot be contained by any known abdominal support. They suffer from abdominal pains and discomfort, and "indigestion," and are discouraged with life and believe their affliction cannot be cured.

The photograph of Mrs. B shows not only an obese woman with a recurrent umbilical and low midline incisional hernia, but one who is suffering from adipose pituitary dystrophy. She was hardly able to walk before treatment, and for years was unable to put on her shoes or get out of bed without help.

Like all of this group she has tremendous breasts, a large abdominal panniculus, abnormal deposits of



fat over the posterior aspects of her upper arms and shoulders and over the inner aspects of her thighs, and in her popliteal spaces and over her buttocks. Her lower arms and legs, her hands and feet are small in proportion to the rest of her body. Such abnormal fat deposits are reduced by diet with great difficulty. They can, however, be removed by surgical excision.

DEFINITION

1. A recurrent umbilical hernia is a protrusion of one or more of the abdominal contents through an aperture at the site of the umbilicus, that occurs again after the performance of an operative procedure to repair the original defect.

2. A low abdominal postoperative ventral hernia is a protrusion of one or more of the abdominal contents through an opening at the site of the midline incisional wound from the umbilicus to the pubis.

In practice these two types of hernia should be treated as an entity because if an umbilical hernia is present then there is a weakness in the midline and vice versa.

ANATOMY

1. The anterior wall is the weakest wall that surrounds the abdominal cavity. Its one muscle, the rectus abdominis, is made up of a right and a left half, each arising by a medial and a lateral head from the symphysis and crest of the pubis. Expanding as they pass upwards, each half of the muscle is inserted medially into the front of the ensiform cartilage and laterally into the front of the fifth, sixth, and seventh costal cartilages. There is a considerable distance between the origin and the insertion of these muscles.

Each half of the rectus muscle is enveloped by an anterior and a posterior sheath of fascia that have their origin in the semilunar tendons, which are made up of the anterior and posterior sheaths of the external and internal oblique, and the transversalis muscles. The semilunar tendons, one on either side of the abdomen, run from the pubic region upward and curve outward, and then inward, to the costal margin and attach to the seventh costal cartilages. The outer border of each rectus muscle is in intimate contact with the semilunar tendon. The posterior and anterior sheath of the recti muscles come together in the midline of the abdomen, and the fibers interlace and form the linea alba, which extends from the ensiform to the pubis, and is normally about ½ inch in width.

2. On the anterior surface of these recti muscles are three or more transverse fibrous bands called inscription tendons, which are adherent to the anterior sheath of the muscle. The lowest of these inscription tendons is at the level of the umbilicus, and the highest at the level of the ensiform. Laterally, they are attached to the strong semilunar tendons, and medially these inscription tendons are attached to the weaker linea alba and to the umbilical fascia.

The long recti muscles have the ability to expand and contract in the direction of their muscle bundles, i.e., longitudinally. But the fibrous inscription tendons resist the widening of the recti muscles. Under severe intra-abdominal tension, the linea alba and the floor of the umbilicus will be pulled laterally and will be stretched and the medial borders of the recti muscles will be pulled further apart in the midline.

3. During early childhood and up to adult life, the omentum is but a rudimentary structure and occupies but a small space in the anterior abdominal

cavity. In middle life, especially in fat women, the omentum becomes more and more infiltrated with lobules of fat, fills more and more space and eventually crowds the other abdominal contents. At the same time the retro-peritoneal fat increases in amount and reduces the circumference of the abdominal cavity, and adds to the crowding.

4. The suspensory ligament of the liver extends from the parietal surface of the liver downwards (one inch or more to the right of the midline) to the umbilicus, and in these fat women the ligaments are always infiltrated or surrounded by large amounts of fat, which extend downward and around the umbilicus.

PATHOLOGY

1. There is always a congenital weakness of the abdominal wall at the site of the umbilicus. For months after the umbilical cord atrophies and falls off, there is only a thin layer of peritoneum and skin present at the site of the umbilicus. Usually during these months there is a small herniation of the umbilicus but as the months go by a fibrous fascia grows around and across the umbilical aperture between the peritoneum and the skin layer and the herniation usually disappears. The umbilical fascia contains little or no elastic tissue, so it can not expand and contract. If the fascia is once stretched, it remains stretched and thinned out.

2. Recurrent umbilical and ventral postoperative incisional hernias usually consist of a sac of parietal peritoneum which is usually thickened by a fibrous infiltration and may or may not be covered by a thin layer of aponeurosis. The sac is often loculated. The neck of the sac remains quite small in primary umbilical hernia and in these hernias only a small portion of the omentum can gain entrance to the sac. The bulk of the omentum acts as a plug and prevents the entrance of any other viscus. But the entrance of the ventral and the recurrent umbilical hernia is wide and more of the omentum, and even a portion of the transverse colon may gain entrance. The omentum, and any other viscus that has gained entrance to the sac, are usually adherent to the walls of the sac. Other portions of the omentum and the transverse colon, and loops of the small intestines are usually adherent to the anterior parietal peritoneum on each side of the old incisional wound.

3. Sometimes there is no sac. In these cases a small aperture has not been closed in the sutured peritoneum, or a tear has occurred in the peritoneum on either side of the suture line, or the thinned fascia has been split, and a nubbing of the omentum enters these holes and acts as a wedge to enlarge them. At times the whole peritoneal suture line will give way. In any case, a large exit is made through which any of the abdominal contents may herniate.

These herniations may be stopped by the sutured fascia or they may break through the sutured fascia and be contained as is usual by the sutured skin. The herniating omentum and large and small intestines invariably adhere to each layer of the abdominal wound through which they herniate.

ETIOLOGY

1. The underlying cause of primary umbilical and low midline abdominal hernias is excessive intra-abdominal tension, which causes over stretching of the abdominal aponeurosis and particularly a thinning out of the linea alba, the fascial floor of the umbilicus, and a diastasis of the recti abdominis muscles of the midline.

The chief causes of this excessive intra-abdominal tension are:

A. Childbirth.

B. A fat bulky omentum.

C. Excessive retro-peritoneal fat.

D. Large ovarian cysts or fibroids of the uterus.

E. Ballooning of the stomach and the intestines with gas.

F. Sudden contraction of the abdominal muscles and diaphragm by coughing or vomiting, or straining at stools, or by over exertion.

An extrinsic factor that is also a potent cause in weakening the anterior abdominal wall is the large abdominal panniculus that these fat women possess. This panniculus is attached to the underlying aponeurosis by loose areolar tissue, and the weight of the panniculus is borne by the aponeurosis in the lower half of the abdomen. In as much as the mid-portion of the panniculus is the larger and heavier, a greater pull is exerted on the aponeurosis in the midline from the umbilicus to the pubis, than in the lateral portions.

2. The causes contributory to the recurrence of these umbilical and ventral hernias after they have been repaired once, or many times, may be the same as those enumerated above, or they may arise from another, or many other causes.

Among these other causes is the failure on the part of the surgeon:

A. To recognize and to treat preoperatively the hypothyroidism, or the anemia, or the circulatory insufficiency from which these fat women suffer.

B. To remove the abdominal panniculus.

C. To remove widely the old scar tissue and the whole umbilicus.

D. To dissect out the layers of tissue around the hernia, and to mobilize them so they can be closed without tension.

E. To dissect off all fat from the peritoneal edges, and to exclude fat between the edges of the peritoneum when suturing it.

F. To free up the adhered omentum from the parietal peritoneum around the old incisional wound.

G. To free up all the intestinal adhesions.

H. To reduce the contents of the abdominal cavity by removing the greater omentum and any tumors that may be present.

I. To recognize small tears that occur on either side of the suture line in the peritoneum through which a nubbing of omentum can and usually does protrude and start another hernia.

J. To provide adequate postoperative antibiotics to prevent infection of the wound and respiratory infections.

K. To close the wound so that all the layers will act together to withstand postoperative strain on the wound.

L. To provide proper low abdominal support for the wound.

M. To demand from the anesthetist the complete relaxation of the abdominal musculature when the wound is being closed.

PREOPERATIVE TREATMENT

It is practically impossible to persuade these fat women to adhere to a fat reducing diet. After weeks of attempted starvation when they do not discern any appreciable reduction of poundage, they resume their old habits of eating. These weeks, however, can be used to improve their circulatory systems, by the judicious use of thyroid substances, digitalis and iron. These women before the days of antibiotics and intravenous replacement therapy were always poor surgical risks. Postoperative pneumonia, gastric distention, paralytic ileus, phlebitis, fat necrosis and wound infections were such frequent complications that adequate surgery could not be attempted without grave risk to life. But today, adequate surgery can be performed without undue risk.

OPERATIVE PROCEDURE

The operation of choice is a multiple one that tends to nullify most of the causes that lead to the recurrence of these hernias. The operation is the same whether it is a repair of an umbilical or low ventral hernia or both. It should be done quickly by a skilled team that includes a well trained anesthetist, a careful operator and good assistants.

A. Removal of abdominal panniculus:

The surgical removal of these large fat rolls of abdominal fat is not difficult but care must be taken in the placement of the incisions so the closure of the wound can be accomplished without tension. It is well to make a small nick in the skin above the umbilicus and another one just above the center of the mons veneris in order to keep these central points located to facilitate accurate closing of the wound.

A transverse incision starting at the outer border of one side of the abdomen at the level of the umbilicus is swung directly across and above the umbilicus to a corresponding level on the opposite border. Clamps are placed in the skin on each side of the midline and over the most dependent portion of the panniculus, and an assistant lifts the panniculus vertically. The operator, by placing one hand above the base of the panniculus and the other below it in the midline and bringing the examining fingers together, can easily determine the midpoint below the panniculus through which the lower elliptical incision can be safely made and still allow the skin to be closed without undue tension. When this point is chosen, then the second incision starting from the same point on the outer border is swung downward and below the panniculus, through the chosen midpoint, then curving upward joining the first incision on the opposite side of the abdomen. These incisions must start and finish well around to the flanks if the whole roll of abdominal fat is to be removed in toto. The incision through the subcutaneous fat under the upper skin incision must be made obliquely upward and that through the subcutaneous fat under the lower incision must be made obliquely downward to the aponeurosis. By making these incisions oblique a much larger area of fat can be removed and a better cosmetic result obtained. The skin, including the umbilicus and all the subcutaneous fat between the incisions, can be easily dissected from the aponeurosis and the whole panniculus removed. Care must be taken in dissecting the midline in order to identify the hernia sac or any herniating viscus if there is no

sac. The removal of this large roll of fat serves four purposes:

1. It provides a good vision of the hernia and the surrounding anatomy and the amount of diastasis recti.

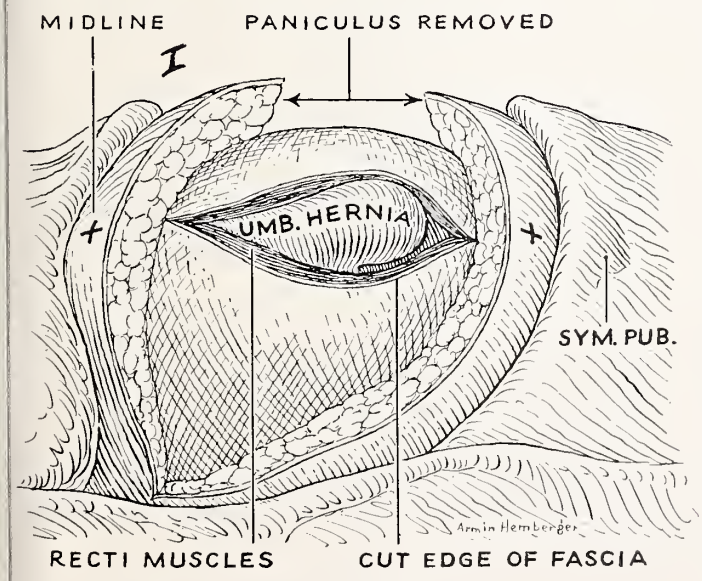
2. It removes a large ponderous fat mass that will cause an extrinsic pull on the suture line if it is not removed.

3. It removes a cumbrous mass of unnecessary tissue that is unsightly and interferes with bodily movements.

4. It removes a source of shame and ridicule which often causes mental depression, and intensifies inferiority complexes.

B. Mobilization of recti muscles:

The incisions through the aponeurosis should be vertical ones that start above the umbilical aperture and swing downward, one on each side of the base of the hernia and along the medial borders of the recti muscles so these borders are exposed and mobilized. It is difficult to separate the borders of the recti muscles around the umbilicus because of the inscription tendons. These transverse fibrous bands are closely adherent to the anterior surface of the aponeurosis in this region and can be freed only by sharp dissection. Drawing No. 1 pictures the transverse abdominal incision through the skin and the oblique incisions through the subcutaneous fat and the vertical incisions around the hernia and through the deep fascia exposing the medial borders of the recti muscles.



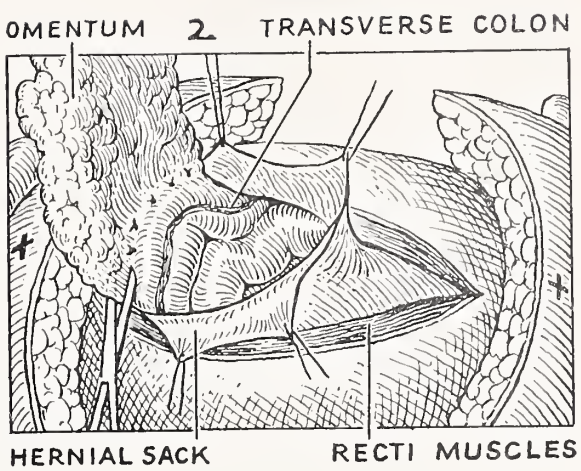
C. Treatment of herniating visci.

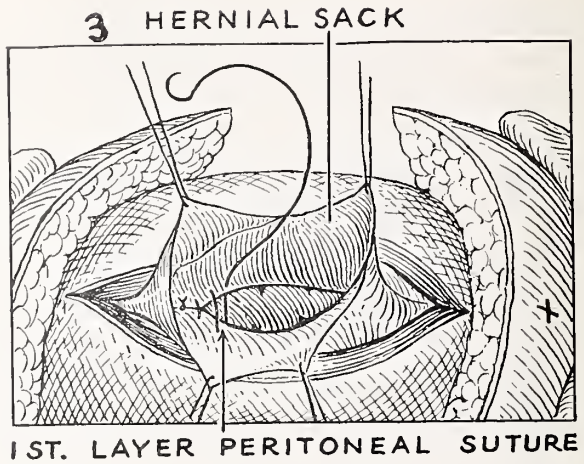
If there is no sac present, the herniating abdominal contents must be carefully dissected from the skin and the subcutaneous fat and deep fascia down to their attachments to the peritoneal edges and freed from these. The dissection must be sharp and clean without pulling and traumatizing by instruments and rough handling.

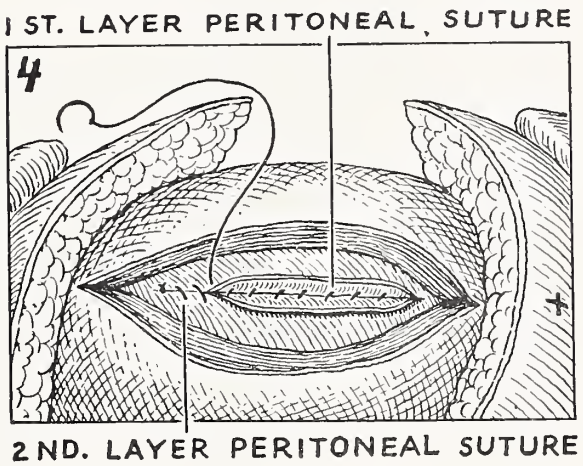
If a sac is present, it should be opened vertically and all intestinal loops that are adherent to the sac or abdominal wall or to each other should be freed by sharp dissection. This is to prevent interference with normal peristalsis and to avoid partial obstruction with resultant post operative distention, causing an increased intra-abdominal tension. Intestinal adhesions interfere with the normal gastric and intestinal movements and give rise to symptoms such as abdominal cramps and pains, gas, nausea, fullness after eating, and constipation.

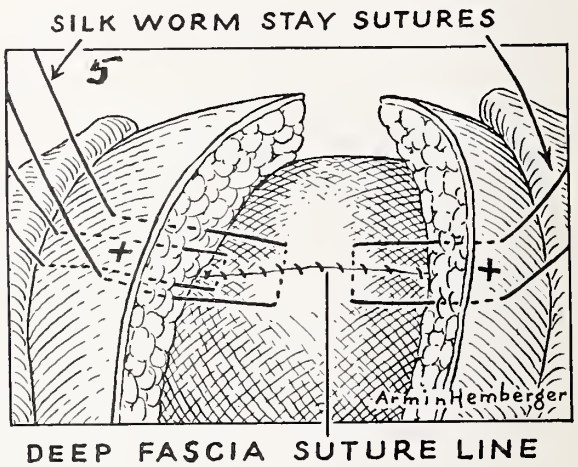
If the omentum is freed up from the sac and dropped back into the abdominal cavity, its traumatized surfaces will immediately readhere to the sutured peritoneum and with every movement of the abdominal wall, whether caused by coughing or vomiting, or by intestinal peristalsis, there will be a constant drag on the suture line. If a small break occurs in the peritoneum during the suturing, it is invariably a nubbing of the omentum that enters this aperture which acts as a wedge for further enlargement. The omentum has been called the watchdog of the abdomen, but the author has removed hundreds of omentums and has observed these patients for years without noting any bad effects following the removal of this tissue.

D. Total omentectomy,[2] as illustrated by Drawing No. 2, is a simple procedure and takes but a few minutes to perform, and causes no shock. The omentum and transverse colon are lifted into the wound, and then beginning on one side or the other, plain catgut ties are passed through the base of the omentum where it attaches to the transverse colon, and the omentum clamped distally to the tie and cut between tie and clamp. This procedure is continued along the length of the transverse colon, and the whole greater omentum is removed. Care must be taken that square knots are used and tied firmly. It is well to review the field of operation before dropping the transverse colon back into the abdominal cavity, because it will retract well up into the upper abdomen after the omentum has been removed and a bleeding vessel may escape notice. If there are large ovarian cysts or fibroids present, these must be removed in order to give more space for other abdominal contents.









E. Closure of abdominal wound:

Accurate and complete closure of the peritoneum is absolutely essential. Before this is attempted, the anesthetist must be instructed to relax the patient completely. The peritoneal edges must be brought into apposition without any intervening fat. The suspensory ligament of the liver extends down to the umbilicus, and it is always surrounded by a layer of fat that covers the peritoneum just above and around the umbilicus. This fat must be carefully dissected away from the peritoneum just above the umbilicus, so that the serous edges of the peritoneum and not the fat will be brought into apposition. Care must be taken to close the very top edges of the incised peritoneum. The needle should be passed through the peritoneal edge and deep enough to take a bite of the posterior sheath of the recti muscles. If there is a hernia sac present, the excess sac should not be removed until the first layer of peritoneal sutures are placed as pictured in Drawing No. 3.

After this continuous plain catgut suture is placed, the excess sac is removed to within ⅜ of an inch from the sutured peritoneum, and a second layer of plain catgut, as pictured in Drawing No. 4, is whipped over these cut edges to reinforce the first line of sutures. If a rent in the peritoneum occurs on either side of the sutured line, it must be carefully closed by interrupted plain catgut sutures placed deep enough to include the posterior sheath of the recti muscles. Before closing the peritoneal cavity it is well to instill 400,000 units of penicillin in saline to combat the tendency to develop peritonitis.

The recti muscles are brought together in the midline by plain catgut continuous sutures passed through the borders of the muscles. The transverse fibrous bands that cross the recti muscles at the level of the umbilicus are a definite help in providing better healing, and a stronger union between these muscles.

The silk worm stay sutures are placed as illustrated in Figure No. 5. The top suture passes through the skin ½ inch to one side or the other of the midline,

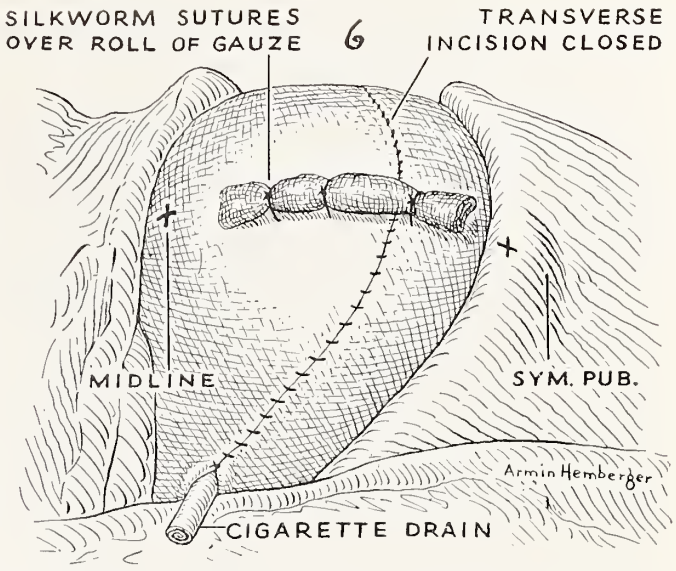
and about 2½ inches above the center of the upper transverse incisional wound and then passes through the subcutaneous fat and through the sutured fascia about 1 inch from the top of the vertical incision, and then out and upward through the subcutaneous fat and the skin ½ inch to the other side of the midline opposite the point of entrance. The second stay suture is similarly placed, but it pierces the skin about an inch above the center of the transverse incisional wound. Two other stay sutures are placed below the center of the lower transverse incision in a similar way to support the lower half of the sutured fascia.

Penrose or cigarette drains are placed beneath the subcutaneous fat from the midline to the outer angle of the wound as shown in Drawing No. 6. The subcutaneous fat may be closed by interrupted plain catgut, and the skin is closed with silk. The silk worm sutures are tied snugly over a roll of gauze. This prevents any cutting of the skin by the catgut sutures. Flat gauze is placed over the wound and a supporting elastoplast bandage is applied from the vertebral column entirely around the abdomen and directly over the incisional wound. After the drains are removed on the third day, another elastoplast support is applied in the same manner, and after each subsequent dressing for at least three weeks. A good low abdominal corset should be worn thereafter. The sutures are all allowed to stay untouched for 12 days or longer.

POSTOPERATIVE TREATMENT

Postoperative nausea and vomiting, and gastric distention must be corrected immediately, if it occurs, by the use of gastric drainage. A rectal tube is used to combat colonic distention.

Four hundred thousand units of penicillin are given daily until the temperature is normal, to prevent pneumonia, wound infection, and peritonitis.



Whole blood and electrolytes must be administered as needed.

These patients are allowed out of bed after the third day if they so desire.

CONCLUSION

A description of the anatomy and the gross pathology of umbilical and low ventral hernias as they occur in fat women, has been presented. The numerous causes that lead to the recurrence have been listed. Curative procedures have been enumerated which, if followed meticulously, should result in fewer recurrences of these hernias in fat women, and should restore health and happiness to these unfortunate human beings.

REFERENCES

1. Cave, H. W., M.D.: "Umbilical Hernia," Textbook of Surgery by American Authors, 3rd edition 1944, p. 1387.

2. Larkin, C. L., M.D.: "Omentumectomy As A Safeguard Against the Recurrence of Omental Adhesions," New England Journal of Medicine 222:208-213, 1940.

POLITICAL MEDICINE

CONGRESSMAN JAMES T. PATTERSON

IN A gathering of doctors so representative as this—I feel somewhat overawed in prescribing for the ills of our citizens. As a practitioner in government, I shall confine myself to that field and leave medical and psychiatric diagnoses to you who are better qualified.

Upon entering the practice of medicine, each of you subscribed to the Hippocratic Oath. In essence, it provides that you shall minister to the needs of your patients without qualification. It is now proposed that somewhat the same system be inaugurated for persons entering political practice. Recent dis-

Remarks made at the Litchfield County Medical Association, Torrington, October 2, 1951

closures of wholesale graft and corruption in our Federal Government have raised the question of a way to assure ethical conduct.

Perhaps we need a code of ethics for those in government service. Some of the professions—notably medicine and law—subscribe to this theory of conduct. However, it must be remembered that each of you—as members of the medical profession—is bound by even a higher code than that prescribed by your governing association. Assuredly, citizens in government should be bound in the same manner. When—from birth—we align ourselves with the Church and attest to our belief in one God, a moral responsibility rests with us. It is a responsibility more severe than any man-made ethical code. Laxity in morals is directly traceable to laxity in Christian living and belief. There has been no relaxation of moral responsibility in God's sight. There will be none. If we will examine ourselves and our actions in this light, a more fitting moral climate may result.

Moral depravity is not restricted to acceptance of mink coats, deep freezers, or bribes. The high incidence of mixtures of crime and politics cannot be lightly regarded—but it does not have the national impact which may be attributed to other evidences of moral decline.

An English student visiting for the summer in Connecticut was a recent visitor to my office in Washington. He was anxious to observe—and to become more fully acquainted with—our system of government. A statement he made at that time could be considered very lightly, but coming from one who had only a short time to examine our system, it was somewhat shocking. He said that it seemed we did not operate—as we universally claim—under a two party system. To him, it was evident that the United States was governed largely through the influence of pressure groups. During his stay he had noted the credit—or lack of it—for legislative accomplishment was attributed to one group or another, rarely to a political party.

If we give a little sober thought to this analysis its correctness is evident. In the Congress we are beset by "rural blocs" and "city blocs." Members are characterized as "stooges" of the C.I.O. or the N.A.M. Dependent upon your choice of information, we are alternately "reactionaries" or "radicals," "fascists" or "communist." The honest sober fact is that almost without exception members of Congress are sincere, hard-working public servants doing a difficult task to the best of their varied abilities.

The moral depravities resulting from many pressures are far more sinister and of greater consequence than disclosures of graft and corruption. They color the national thinking—they divert our mental processes from leadership to a tendency of "following the crowd." It is refreshing to find on my desk mail from a citizen expressing his or her own opinion on subjects of national interest. Often it is a tailored opinion, previously expressed by some national organization. As men with medical training, you often warn the patient of the consequences of nonuse, for long periods, of bodily functions and parts. The same holds true for the mind. Should we allow our thinking to be done for us; the time will shortly be with us when thinking for ourselves will become increasingly difficult. Along this way lurks the dictator form government. We can be captives of our own negligence.

The tendency to cater to organized groups—to take the easy way—has permeated our national government. It has filtered through to State and local governments. It is distressing and unhealthy. Government must be responsible to the people—and the people must be responsible for government. In any other course lies power for power's sake and a certain loss of freedom.

One of the foremost examples of tugging and hauling by various groups in the political arena is the problem of health legislation. Of all places in our national life where strident partisanship should be avoided, the two most obvious are the collective security of our people and the health of our citizens. Yet we find that in the jurisdiction of national health, bitter name calling and organized pressures are most evident. Make no mistake about it, the lobbying goes on in both camps. Those who desire no change—however beneficial some change may be—and those who would transform medicine into a bureaucratic nightmare are both guilty. I cannot indict too greatly the unthinking few who see any change as undesirable. They will remain as obstacles in the path of progress which will run past them. The vociferous proponents of socialistic medicine perform an even greater disservice to our citizens. They desire the stranglehold of exorbitant power in the field of health. Their depredations are not easily undone.

Each of you in attendance has changed diagnostic

techniques, methods of operation, and even modes of treatment in the past few years. Improvements in medicine have been phenomenal. Longer life and more healthful life is now a certainty for our citizens. Medicine has progressed and with recent strides in science will progress even faster and further. It is fantastic therefore to presume that no progress can be made in bringing the wonders of preventive and curative medicine to more of our people. Financial considerations loom as the greatest obstacle to this achievement. A way must be found to overcome this obstacle. It will be found through the cooperation of physicians with our national legislature.

The alternative to this cooperative effort is not attractive. The exponents of socialized medicine will trade on real or imaginary abuses to foster their extreme legislation before Congress. Socialism in this instance is no scareword. Should Congress adopt a counterpart of the British medical plan, it would be a reality.

A middle ground must be found to accomplish the worthy objective of bringing medical treatment to all of our people. A real start has been made in some instances. Some of the midwestern States, for example, adopted State plans for encouraging doctors to practice in rural areas. As the financial return from such practice is not nearly so great as in large population areas, some subsidiary payment system is needed. The people of rural areas need the services of doctors as greatly as do the city dwellers. The voluntary insurance and nonprofit plans for hospitalization have assured adequate treatment to many who otherwise might not have had it. The more recent addition of surgical payments has increased the value of this coverage tremendously. The unselfish contributions of American doctors to clinics should not go unnoticed in any evaluation of the national health picture. The free treatment obtained in this manner would be impossible to figure in dollar value. Notwithstanding these recent material benefits, much remains to be done.

The medical schools of this country are unable to accommodate the students desiring such training. Excessive taxation has dried up the sources of endowments which might have corrected this inadequacy. It is clear that the Federal Government must assist medical schools to assure a source for the doctors of tomorrow. This can and should be done without the heavy hand of bureaucracy controlling the educational system.

The military departments are notorious wasters of talent. During World War II there were many places where proper treatment could not be obtained because of an insufficiency of medical personnel. There were contrary examples of doctors getting in each other's way at other locations. Even now the system of calling up doctors and the placement of them could be vastly improved. Medical talent is one national resource we cannot afford to waste.

The fee system of American medicine results in many abuses. Based usually upon the ability to pay, the low income family many times finds even the minimum payment beyond its reach. Herein lies one of the main faults, which the eager beavers to the left want to cure by just a little bit of socialism. To be perfectly fair about it we should examine both sides of the coin. The doctor—having devoted many years of his life to study and training—feels entitled to receive reasonable payment for his services. The doctor has, in addition, invested many dollars in equipment and a library. Until we accept the theory of Communism and its concept that all material goods shall be equally divided, there can be no quarrel with the doctor receiving proper compensation for his services. Yet we cannot, in good conscience, neglect the health of the poor because of their inability to pay. One sick person in a community is like one rotten apple in a barrel; the chances are great that many more will be infected. It is a problem for all of us to face—and one which cries out for a solution.

Surely there is a way—a fair, American way—to resolve these difficulties. There is no need to go overboard in adopting a British Plan or any other plan devised abroad. We are not a nation bereft of ideas. A program originated by us and operating without benefit of interference by the Federal Government can and will work. It must be a program initiated by doctors through their governing professional organization. The program which brings greater benefits to our people must also retain the concept of American enterprise. Congress is eager to have such a program for consideration. I would predict its adoption without serious controversy.

The public health is not a question to be decided in the realm of partisan politics. It is vastly too important to be in the midst of a mud-slinging controversy. The doctors of America have contributed without equal to the well being of our people. Let the good work continue and flourish even greater.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMIS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
BENJAMIN V. WHITE - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

It Can Be Done

Dr. George P. Berry, dean of Harvard Medical School and new president of the Association of American Medical Colleges, continues to maintain his stand favoring federal aid to medical schools. In a report as chairman of the Association's committee on financial aid to medical education, Dean Berry observes that "the financial plight of the medical schools continues to be desperate" and describes the accomplishment to date of the National Fund for Medical Education as "modest," with progress being made "steadily but slowly."

Dean Berry has always been pessimistic when it comes to any means of financial help for the medical schools short of federal aid. In a meeting of the Harvard Medical Alumni Association at Atlantic City last summer it was repeatedly pointed out to him that physicians on the whole wanted none of federal aid to medical schools because they feared that where government subsidizes, there it controls. He was likewise reminded that no real effort had been expended to build up an endowment fund with gifts from medical school alumni, at least in the case of Harvard. Now he discourages efforts being made to make the National Fund for Medical Education the success it should be. He goes on to say in his report: "Many schools may be driven to increasing tuition fees. In the face of soaring costs, this expedient promises little, for it will lead rapidly to diminishing returns both in terms of dollars and the breadth of student selection."

It takes time to make physicians realize they owe a debt to their alma mater which has never been paid. Once this fact sinks in the results will be compatible with the experience of a Harvard Medical School alumnus in Dallas, Texas. "In one of our little hospitals in Dallas," he said, "we wanted recently to add a wing. Seventy of us went into a room, closed the door and talked it over—and raised $100,000 right there. It can be done."

Psychiatry in General Hospitals

The progress report made recently by the Society's committee on mental health shows a realistic approach to one of the most serious health and welfare problems in our State. The report emphasizes the imoprtance of early recognition and treatment of emotional problems as a concept of general agreement in all professional circles. The responsibilities of the public in the preventive aspects of mental disease must be made manifest in a more forward looking attitude on the part of those responsible for the service functioning of general hospitals. The report further emphasizes that inasmuch as it is stated that emotional disorders account for at least 25 per cent of all admissions to general hospitals, every such hospital should have a psychiatric service the same as it has medical, surgical and obstetrical services.

Of high significance in the report are the results of a survey by means of questionnaire of 34 general hospitals in Connecticut. This reveals that only seven hospitals offer inpatient psychiatric care. This shows that aside from a few urban centers the entire patient load is passed on to the state hospital system or the private sanitaria for intramural management. "Because of this fact," states the report, "it naturally follows that teaching programs in psychiatry for residents and interns are few and opportunities for

physicians and psychiatrists to share problems are but slightly more frequent. Only 16 hospitals have attending psychiatrists while 8 others have consulting psychiatrists. Thus, 10 hospitals offer no psychiatry whatsoever. Nurses fare better than doctors inasmuch as 41 per cent of the hospitals provide training in psychiatric nursing, largely through affiliation with the State hospitals. These facts lead to the inevitable conclusion that the teaching and practice of psychiatry in the general hospitals of Connecticut is far behind the teaching and practice of other branches of medicine, a condition that should be corrected.

"Until recent years the only places available for the care of the mentally ill were the many State and the few private institutions. Most of the public mental hospitals, including those in Connecticut, are now crowded, exceeding their normal capacity by 20 to 35 per cent. Furthermore, the incidence of mental illness is increasing. The population of mental hospitals has grown over 100 per cent in the past 50 years, due not only to greater total population of the country, but also to increased life expectancy. Thus today approximately one-third of the patients in such hospitals are over 65 years of age. For these reasons the medical profession and general hospitals have an ever increasing responsibility to attack mental illness in its early stages with modern methods of treatment. By and large the general hospitals of Connecticut are not meeting their obligation to care for the ill of the community, inasmuch as a very large segment of those sick are mentally and not physically ill."

The report points out that psychiatric units in general hospitals relieve the state institutions of many diagnostic admissions and short term psychoses which can be quickly and effectively treated. Furthermore a patient who can be treated promptly in his own community is saved time, money and untold suffering. The advantages of psychiatry as a partnership to other hospital services is obvious. Patients with delirium, drug psychoses and lesser emotional disturbances as part of a symptom complex are best treated by the psychiatrist as part of the professional team. The committee recommends that the State Medical Society should take a position of leadership in sponsoring a program designed to bring an inpatient psychiatric service to every general hospital in Connecticut.

Dr. Franklin S. DuBois, chairman, and his associates on the committee are to be congratulated for a timely study of a hospital situation in our state which needs concerted attention and effective correction.

Professional Relationships

We present in this issue a report of the interim session of the AMA. Of particular interest is the report of the Board of Trustees to the House of Delegates on the Relation of Physicians and Hospitals, which was approved by that body. Certain of the recommendations are noteworthy, such as the proposal that each component medical society and each State society appoint a committee on hospital and professional relations and, if possible, promote a liaison between such groups and local and State hospital associations. Other parts of the report no doubt will be the subject of discussion seeking clarification. All in all, the report represents progress toward resolving many problems in an area which under the stress of modern times will have little tendency to remain static. We believe, and we must continue to believe, that integrity and honesty of purpose still serve the vast majority of physicians in their professional relationships, for it is on this premise that must be resolved whatever differences of opinion that may arise.

Society Loses Oldest Living President

When William L. Higgins of Coventry died on November 19, 1951, the Connecticut State Medical Society lost not only a faithful member but also its oldest living past president. Of the vintage of such leaders in Connecticut medicine as William H. Carmalt, Everett J. McKnight and Nathaniel E. Wordin, Dr. Higgins was president of the Society in 1906-1907 when its membership numbered 780. For many years he had served as a delegate from Tolland County, even then the smallest of the County Associations with a membership of 21, and in 1908 he was *the* Committee on National Legislation of the State Society.

Dr. Higgins was a colorful figure locally. He served the towns of Columbia, Coventry and Andover as health officer for over 50 years. He was first selectman of Coventry for 16 years and a Tolland County commissioner for 12 years. From 1929 to 1933 he was Secretary of the State and served seven terms as a representative to the General Assembly. He was known as the father of dirt road legislation in Connecticut. From Hartford Dr. Higgins went on to Washington, representing the Second Congressional District in the 73rd and 74th Congresses.

Catastrophic Illness Insurance for Members

Insurance against the high cost of long illness is a matter of concern to all persons interested in prepayment for the expense of sickness. Only a few experiments have been tried in this field and the Society is pleased to announce that after months of planning by the representatives of the Commercial Insurance Company of Newark, New Jersey, and a special committee of the Council, this unique coverage will be offered to members early in 1952. The Commercial Insurance Company has carried the highly successful group accident and health contract for the Society for a number of years and has paid hundreds of thousands of dollars in benefits to Connecticut physicians.

The new catastrophic illness contract will be available to members, whether or not they are covered by the group health and accident plan and the insurance will cover hospitalization, professional services, nursing, drugs and appliances, for long illness up to a maximum of $5,000 after the insured has paid $500 and can be purchased for members of one's family.

Such insurance has never before been offered to a medical society and details will be distributed to members at an early date.

Your State Medical Journal

Lest our readers think that the job of editing a State medical journal consists only in writing a few editorials and making sure the printer has enough material each month to fill the pages, we bring you a flash from a recent gathering in Chicago. Here were editors and business managers representing the State journals from Seattle, Washington to Jacksonville, Florida and from Portland, Maine to Phoenix, Arizona. Nor was it just a social gathering, an opportunity for renewing friendships. Common problems were discussed and means of improvement suggested. Walter Kahoe, director of the medical department of J. B. Lippincott Company; Harry L. Shaw, general editor of Harper and Brothers; Professor Lester L. Hawkes of the University of Wisconsin School of Journalism; William A. Richardson, editor of *Medical Economics;* and Roger I. Lee, distinguished physician and scholar from Boston—these as well as experts from the advertising and editorial departments of the American Medical Association brought valuable ideas to the conference and contributed immeasurably to the discussion.

Eager to make the State medical journals a successful factor in guiding the physician's thought and action, the job of an editor was unmistakably and clearly outlined. Simplicity of style in medical writings was urged. Dull documentation was discouraged. Dr. Lee in his Pickwickian manner decried the prolixity and stuffiness of many of the specialty journals. Mr. Richardson pointed out how to secure and make interesting articles on socio-economic problems. Professor Hawkes in detail outlined the most attractive arrangement of type, headings, etc., in the mechanical makeup of a medical journal.

Nor were the problems discussed entirely those of the writer and editor. The business management methods of the small State society journals such as Nebraska, and of the large ones such as Michigan, were presented by the lay managers of those two journals as representative of the group at large. Printing costs which in California have risen only 3.6 per cent during the past five years were cited in contrast to those of West Virginia which have increased 125 per cent in the same period. Sources of advertising revenue were explored and the State journals were reminded that the Advertising Bureau in Chicago, operated under the aegis of the AMA, now carries on a business of approximately $800,000, all for the benefit of the member State journals. Only one State medical journal has reported a profit during the year 1950.

It is immediately apparent that the State medical journals are becoming big business in the program of organized medicine. The desire on the part of the editors to create a steady improvement in the product is a commendable one; likewise, the desire on the part of the business managers to at least break even in getting these various medical society publications to their members shows a hopeful trend in this era of deficit spending. More and better scientific papers and case reports from members of the State medical societies are needed. Constructive criticism by the readers is welcomed in the editorial hall. Increase in local advertising and a realistic support of all the State medical journal advertisers by our readers is becoming an increasing necessity. The standards of medical writing and of medical advertising have been established by the State medical journals themselves. They are high but not unattainable. Great as has been the improvement in State medical journalism during the past two decades, there is yet room for further progress. Toward this end the State medical journal editors are constantly striving.

PROGRESS IN CLINICAL MEDICINE

IRON METABOLISM IN HEMOSIDEROSIS AND HEMOCHROMATOSIS

CLAIR RANKIN, M.D., *Hartford*

THE disease complex of hemochromatosis has long been regarded as a medical curiosity bearing a hopeless prognosis. The pathological diagnosis of massive hemosiderosis has most often been made at autopsy or as an incidental finding in a biopsy specimen from the liver at operation or from an excised lymph node or spleen. In either case the significance of the diagnosis in terms of disturbed iron metabolism has been largely overlooked.

The great expansion of blood banking facilities in this country in the present decade, dating from World War II, is making ever increasing quantities of blood available to the practicing physician. With the availability of blood for transfusion goes the responsibility for recognizing the potentially harmful effects of the blood transfusion as a therapeutic agent. Much has been written of the immediate harmful effects of transfusion, including circulatory overload and the serious hemolytic reactions resulting from gross incompatibilities or from contamination. One purpose of this review is to point out a more insidious danger in the use of multiple blood transfusions in the long-range treatment of chronic refractory anemias.

A brief review of current concepts of iron metabolism is presented and the pathogenesis, diagnosis and prevention of excessive iron storage is discussed.

Hemosiderosis may be described as the storage of abnormal quantities of iron in the parenchymal and reticulo-endothelial tissues as hemosiderin with concomitant fibrosis and eventual functional impairment of the involved tissues. Normally iron is stored in the parenchymal cells of the liver, in the reticulo-endothelial cells of the spleen and bone marrow, and to a lesser degree in other tissues as a complex of protein and polymerized ferric hydroxide known as ferritin.[1] The micelles of ferritin are not detectable by microscopic examination of these tissues. Hemosiderin,* on the other hand, takes a stain and is visible under the microscope. It apparently represents an exaggerated clumping together of the ferritin micelles which results when the storage cells are crowded with quantities of iron far in excess of normal. When this situation develops tissues other than the liver, spleen and bone marrow may be involved, such as the lymph nodes, pancreas, myocardium, thyroid, skin, lungs and kidneys, as well as other parenchymal tissues. Whether the associated fibrosis is the result of the disturbance in cellular metabolism brought about by the excess stores of iron or is an independent process has not been established.[2,3] There is some evidence to suggest, however, that the fibrosis may at least initially and in part represent an independent process.[3,4]

In any event, when cellular function is grossly disturbed in the various tissues the clinical picture of hemochromatosis appears. When fully developed it is characterized by hepatic cirrhosis, diabetes mellitus, myocarditis, bronze pigmentation of the skin, and in some cases, hypogonadism. The etiology of this condition is varied. The so-called endogenous or primary form may be due to an inherited defect in iron metabolism or it may result in certain parts of the world from bizarre dietary factors. The so-called exogenous or secondary form is much more common for it represents an acquired massive hemosiderosis developing in the course of a chronic refractory or hemolytic anemia which has in most cases been treated by great numbers of blood transfusions through the years—hence the term "exogenous." In these latter cases the full clinical picture of hemochromatosis is usually not present. For example, diabetes may not be present.

There are other important differences between

*This use of the term "hemosiderin" is to be distinguished from the hemosiderin released from denatured hemoglobin in normal hemoglobin catabolism.

these two entities, which are generally distinguished as *primary hemochromatosis* and *transfusion hemosiderosis*. The hemosiderin deposits in primary hemochromatosis are usually heaviest in the liver and pancreas whereas the liver, spleen, bone marrow, and kidneys are prominently involved in transfusion hemosiderosis,[5] the involvement of the kidneys being particularly marked in the presence of a recently active hemolytic process. After a period of time, however, the final distribution of pigment in the two diseases may be indistinguishable. The iron-containing pigment of hemochromatosis is characteristically accompanied by a poorly defined pigment called "hemofuscin." Hemofuscin does not contain iron, may appear gray, yellow or brown, and may well represent several substances, the result of abnormal cellular metabolism. Finally, anemia is characteristically absent in primary hemochromatosis, whereas it is a prominent feature of transfusion hemosiderosis, representing as it does the underlying disease state upon which hemosiderosis is superimposed.

PATHOPHYSIOLOGY OF IRON METABOLISM[1,2]

Whereas the normal body content of iron is about 3 to 5 Gm., of which approximately 15 per cent is storage iron (ferritin), the body of a patient dying with massive hemosiderosis may contain 5 to 12 times this amount, principally as hemosiderin. The liver is the principal storage organ for iron. In conditions of iron excess the iron stores of the liver are increased before those of any other organ and in extreme cases may contain 50 to 100 times the normal amount.

Normally the body's stores of ferritin are maintained within fixed limits by a very strict regulation of iron absorption and excretion. Absorption is normally held at a minimal level (about 1.5 mg. a day) consistent with body requirements and loss. Absorption is closely regulated through a mucosal bloc mechanism involving the mucosal cells of the gut, principally of the duodenum. Granick has reviewed the factual basis for assuming that such a mechanism exists and has constructed an hypothesis to explain the working of this mechanism.[1] Granick feels that in some way, directly or indirectly, the presence of normal quantities of ferritin in the mucosal cells offers a bloc to further absorption of ferrous iron. On the other hand the bloc is overcome when the ferritin of these mucosal cells is reduced to ferrous iron and as such released into the blood stream. It has been observed that in the presence of chronic anemias there is increased absorption of iron.[6,†] The same is true after acute blood loss, though after a lag of about a week. Under these circumstances the low oxygen supply to the mucosal cells may in some way be responsible for the reduction of the ferric iron of ferritin to the ferrous iron, which then enters the blood.

Once in the blood ferrous iron is combined with a protein (a beta-1-globulin) to form a complex variously designated in the literature as siderophilin, transferrin, iron-combining-protein, *et cetera*. Each molecule of this complex can bind three ferrous ions. However, normally this protein is only one-third saturated with iron, giving values of around 100 gamma per cent (range: 60-150 gamma per cent). These values are abnormally elevated in hemochromatosis, transfusion hemosiderosis, some hemolytic anemias and some conditions characterized by impaired hemoglobin synthesis, such as pernicious anemia, certain refractory hypoplastic anemias, nutritional deficiency anemias and cirrhosis of the liver.

When the transport iron reaches a storage depot, the ferrous iron is reconverted to ferritin (and hemosiderin) and stored as such. When needed by the bone marrow for hemoglobin synthesis these steps are once again reversed and ferrous iron is made available. Whether or not the iron of hemosiderin can readily be made available for hemoglobin synthesis has not been determined.

The iron released from subsequent hemoglobin denaturation re-enters this iron cycle and is eventually reutilized in hemoglobin synthesis. The erythrocyte iron turnover has been estimated from isotope studies to proceed at the rate of about 1 per cent per day. About 1 mg. of iron per day is normally lost through the urine and through the sloughing of ferritin-containing mucosal cells from the gut.

PATHOGENESIS OF INCREASED IRON STORES[1]

Increased stores of iron may result from decreased utilization or increased absorption of iron, or from the direct introduction into the blood stream of iron as whole blood. Thus in pernicious anemia in relapse, in the anemia of chronic infection or inflammation, and in refractory hypoplastic anemias there is de-

†Some investigators[7] deny the role of chronic anemias, except for iron-deficiency anemias, in causing increased iron absorption. The former view, however, is the one subscribed to in this review.

fective utilization of iron by the erythropoietic tissues and iron stores are increased. Associated with some of these chronic anemias there is increased absorption of iron, with resulting high serum iron levels and increased iron storage. The anemias of chronic infection or inflammation differ in that absorption is reduced or at least not increased and serum iron levels are low.

Chronic hemolytic anemias differ from the above in that there is actually an increased iron utilization, but with an associated increase in absorption and storage.

While the iron stores are mobilized in pernicious anemia when the anti-pernicious anemia factor is supplied and in the anemia of chronic infection once the infection is successfully treated, the iron stores in the chronic hemolytic and refractory hypoplastic anemias increase with the passage of time and as a result of transfusion therapy. These are the conditions which may eventuate in so-called transfusion hemosiderosis.

In primary hemochromatosis, on the other hand, there is no error in utilization of iron for the synthesis of hemoglobin and there is no chronic anemia to promote increased iron absorption. Nevertheless the intestinal mucosal cells absorb abnormally large quantities of iron. Granick postulates an error in the functioning of the enzymes of the oxidation-reduction system operating in these cells, by which there result a greater tendency for the cells to reduce iron.

Dietary factors have also been incriminated in producing excessive iron absorption. The fact that quantities of iron are said to enter the food cooked in iron pots by the Bantu's of South Africa is considered of etiologic significance in explaining the unusual incidence of hemochromatosis seen in these people.[8] The almost exclusively corn meal diet[9] of the South African negro is held to be an important factor in the excessive absorption of iron. A very low phosphate content[10] of the diet has been found experimentally to lead to progressive increase in body iron stores.

DIAGNOSIS OF INCREASED IRON STORES

In the past the final diagnosis of hemosiderosis has involved the microscopic study of biopsy or autopsy material obtained from the liver, the skin or a lymph node as a rule. A test has also been available for hemosiderinuria[11] in the presence of massive intravascular hemolysis or hemochromatosis.

More recently the popularization of the liver needle biopsy has provided an excellent means for the early diagnosis of hemosiderosis. Since the performing of this biopsy is not without hazard, however, it should be carried out only when absolutely indicated, in the presence of a confirmed normal prothrombin time, and by an experienced operator.

A simple test has been proposed by Rath and Finch[12] for iron excess in the reticulo-endothelial system. It involves the examination of a marrow aspiration specimen stained with a Prussian blue reagent. The quantity of hemosiderin granules noted in the reticulo-endothelial cells of the marrow is taken as a gauge of iron storage. The actual diagnostic value of this test, however, and the assumption that these hemosiderin stores in the reticulo-endothelial cells represent available iron for hemoglobin synthesis has been challenged by Masshoff and Gruner.[13] Further work is necessary on this important point.

TREATMENT AND PREVENTION

The treatment of primary hemochromatosis in the past has been confined to symptomatic treatment of the hepatic cirrhosis, the diabetes mellitus, the cardiac failure, and the hypogonadism, when present. Recent investigators in this field have concluded from phlebotomy experiments and concurrent iron balance studies that the hemosiderin stores in primary hemochromatosis can be mobilized in response to repeated phlebotomies,[2,14] so that the excess iron stores can, in a sense, be drained off. This, of course, could not be done in the transfusion forms of hemosiderosis because of the presence of an underlying anemia. Even in the primary form of hemochromatosis, in which anemia is characteristically absent, it is uncertain how much could be accomplished by reducing the iron stores. The underlying mechanism producing the disease is chronic and progressive and the associated fibrotic changes could not be reversed by reducing the iron stores. Nevertheless removal of excess iron stores by repeated phlebotomies may be worth consideration in cases of primary hemochromatosis discovered early and as an adjunct to conventional forms of symptomatic, dietary (see below), and hormonal replacement therapy.

Although treatment is limited and nonspecific in massive transfusion hemosiderosis, certain efforts can be made toward its prevention. Diligent search

should be made early for contributing etiologic factors in obscure or so-called refractory anemias so that they could be better managed, even if not cured. Cases of familial spherocytic anemia should be recognized early in life and splenectomy carried out. Early splenectomy may also be of value in certain chronic acquired hemolytic anemias.

In addition, the entry of iron via the gastrointestinal or intravenous routes must be held at a minimum. Once it has been demonstrated to be of no value in a given case of chronic anemia, oral iron medication should be discontinued. Not only would the continuation of iron therapy under such circumstances be wasteful, but as already pointed out, intestinal absorption of iron in many forms of chronic refractory anemia is increased while utilization is frequently impaired.

Granick has suggested that the absorption of dietary iron may be reduced by certain dietary measures. The planning of a diet high in phosphates and phytic acid and low in ascorbic acid would lessen the reducing action of the diet and the gastric secretions on ferric iron, thereby limiting the absorption of ferrous iron. The addition of vitamin K to the diet as the naphthoquinone would, he suggests, serve the same purpose by increasing the oxidizing activity of the diet.

Finally, the use of blood transfusions in any chronic anemia must be weighed carefully and held at a minimum compatible with the patient's comfort and welfare. Attempting to maintain a near "normal" hematocrit in such individuals is not only futile but unnecessary and, in the long run, detrimental. These individuals can adjust to a lower hematocrit level quite well in most cases, and this adaptation is disturbed by intermittent efforts to "boost" the hematocrit by transfusions. Indeed, multiplicity of transfusions begets further difficulty in that mild forms of isoimmunization develop which lead to a shorter and shorter life span for transfused red cells. Transfusions are thus ordered more and more frequently and the stores of excess iron mount.

The use of a relatively safe form of iron for intravenous administration (saccharated iron oxide) has recently been introduced into this country from England. It is to be hoped that the use of this preparation will be confined to trial in certain hypochromic, microcytic anemias refractory to oral iron medication. Otherwise, its indiscriminate use might well contribute to the problem under discussion.

SUMMARY

While little can be offered in the treatment of advanced hemochromatosis and transfusion hemosiderosis, definite steps can be taken to retard or prevent the development of transfusion hemosiderosis. These steps include the early recognition of contributing etiologic factors in certain chronic hemolytic or so-called refractory anemias, the early correction of these conditions where possible, the avoidance of useless oral iron therapy, the institution of dietary measures to reduce iron absorption, and finally the limiting of palliative blood transfusions to a minimum consistent with the patient's comfort and welfare.

BIBLIOGRAPHY

1. Granick, S: Iron Metabolism and Hemochromatosis. Bull. New York Acad. Med. 25:403. July, 1949.

2. Finch, C. A., et al: Iron Metabolism: The pathopsysiology of iron storage. Blood. 5:983. November, 1950.

3. Schwartz, S. O.: and Blumenthal, S. A.: Exogenous Hemochromatosis Resulting from Blood Transfusions. Blood. 3:617. June, 1948.

4. Wyatt, J. P., Mighton, H. K., and Moragues, V.: Transfusional Siderosis. Am. J. Path. 26:883. September, 1950.

5. Wyatt, J. P., and Goldenberg, H.: Hemosiderosis in Refractory Anemia. Arch. Int. Med. 83:67. January, 1949.

6. Dubach, R., Callender, S., and Moore, C. J.: Absorption of Radioactive Iron in Patients with Fever and with Anemias of Varied Etiology. Blood. 3:526. May, 1948.

7. Balfour, W. M., et al: Radioactive Iron Absorption in Clinical Conditions: Normal, pregnancy, anemia, and hemochromatosis. J. Exper. Med. 76:15. July, 1942.

8. Walker, A. R. P., and Arvidsson, U. B.: Iron Intake and Haemochromatosis in the Bantu. Nature. 166:438. 1950. (Abstracted in Blood. 6:286. March, 1951.)

9. Gillman, J., Mandelstam, J., and Gillman, T.: Comparison of Chemical and Histological Estimations of Iron and Copper Content of Livers of Africans in Relation to Pathogenesis of Cytosiderosis and Cirrhosis (Haemochromatosis). South African J. M. Sc. 10:109. 1945. (Cited by Finch(2).)

10. Hegsted, D. M., Finch C. A., and Kinney, T. D.: Influence of Diet on Iron Absorption. II. Interrelation of iron and phosphorus. J. Exper. Med. 90:147. 1949.

11. Rous, P.: Urinary Sideroses; Hemosiderin Granules in the Urine. J. Exper. Med. 28:645. 1918.

12. Rath, C. E., and Finch, C. A.: Sternal Marrow Hemosiderin: A method for the determination of available iron stores in man. J. Lab. & Clin. Med. 33:81. January, 1948.

13. Masshoff, W., and Gruner, P.: Das Eisen in punktierten Knochenmark. Acta haemat. 5:19. January, 1951. (Abstracted in Abstr. of World Med. 10:65 (Abstr. 251). July, 1951.)

14. Beyers, M. R., and Gitlow, S. E.: Metabolism of Iron in Hemochromatosis. Am. J. Clin. Path. 21:349. April, 1951.

THE PRESIDENT'S PAGE

WHETHER it be for injury or disease, the acceptance of a patient for treatment gives rise to the professional relationship of physician and patient. This acceptance for treatment—the actual practice of medicine—in giving rise to the professional relationship assumes certain rights and responsibilities. One of the responsibilities of the relationship, particularly in cases of physical injury, is the responsibility of the physician to assist the patient in the honest prosecution of an action to obtain damages or his rights under the Workmen's Compensation Act.

Because the speed of transportation is increasing and industrialization is expanding, physical injuries are constantly increasing in number. In this State, which is a center for the insurance business, our citizens are especially conscious of their rights and privileges under our laws. It is true that most physical injuries and many diseased conditions arising as complications or sequelae of injury are potential causes for lawsuits and the practicing physician must accept the responsibility of, besides giving the patient his best medical care, helping the patient by giving accurate and reasonably complete information and his opinion as to the ultimate outcome of the case to the patient's attorney in the event legal action is instituted. This information should be in such form that the patient's attorney can draft a complaint which will fairly and accurately inform the opposing party of the injury or ailments for which damages are sought, will not be inconsistent with the testimony of the physician as it is to be given in the event he is called upon as a witness and will be calculated to discourage and remove any excuse for exaggerated or unfounded claims for alleged injuries not actually sustained.

These brief observations bring into review the interplay between the two professions, the medical and the legal. And this mutual activity of the two professions is too often so fraught with irritations, antagonisms and clashes that the object of the activity—the preservation of the patient's rights—is lost sight of and becomes a contest instead of a combined project. In order that this common endeavor may be explored, that the service to the patient may be brought to a higher level of quality and that the respect of the two professions be increased, it has been suggested that committees of the County Bar Association and the County Medical Association be appointed in their respective counties and informally but frankly discuss their mutual difficulties and interests. The aspects of professional practices, economics, and other points to increase mutual trust and efficiency could be profitably explored.

Such a committee in one of the smaller counties has already been appointed by the two Associations. Much professional good may readily result.

Brae Rafferty, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
Public Relations

160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

AMA DUES

There is not much time left for the payment of dues to the AMA for 1951. December 31 was the deadline with one month period of grace allowed. DO IT NOW.

Membership Report as of December 10, 1951

COUNTY	TOTAL MEMBERSHIP	PER CENT PAID SOCIETY DUES	PER CENT PAID AMA DUES
Fairfield	699	93.5	78.5
Hartford	824	89.4	78.3
Litchfield	116	99.1	86.2
Middlesex	97	94.8	79.2
New Haven	770	95.5	73.7
New London	155	96.7	80.0
Tolland	16	81.2	81.2
Windham	63	96.8	82.5
	2,740		
Associate members	11		
Total	2,751		

AMA Dues Exemptions

The Board of Trustees established the following exemptions from the payment of AMA membership dues:

"1. Members who have retired from the practice of medicine, provided they are also excused from the payment of dues, in full or in part, by their component societies and constituent associations.

"2. Members over 70 years of age, regardless of whether or not they are in practice and regardless of local dues exemption.

"3. Members for whom the payment of dues constitutes a financial hardship and who are also excused from the payment, in full or in part, of component and constituent society dues for the same reason. In each case, notification of exemption for financial hardship should be made to the American Medical Association by the secretary of the county and state medical society.

"4. Interns and residents not more than five years after graduation from medical school, except that time spent in military service may be excluded in calculating the five-year limit.

"5. Members who enter military service prior to July 1 of any year are exempted from one-half of the year's dues and subsequently during service from full dues."

Number of Connecticut Residents Who Entered Medical School September 1951

NAME OF SCHOOL	NO. OF REGISTRANTS
Yale University School of Medicine	22
Georgetown University School of Medicine	14
George Washington School of Medicine	1
Howard University College of Medicine	3
The Chicago Medical School	1
Johns Hopkins University School of Medicine	1
University of Maryland School of Medicine	4
Boston University School of Medicine	2
Harvard Medical School	7
Tufts College Medical School	16
Albany Medical College	2
Columbia University College of Physicians and Surgeons	11
Cornell University Medical College	6
New York Medical College, Flower & Fifth Avenue Hospitals	18
New York University College of Medicine	2
University of Rochester School of Medicine	1
Syracuse University College of Medicine	3
Jefferson Medical College of Philadelphia	1
University of Pennsylvania School of Medicine	3
University of Vermont College of Medicine	6
Medical College of Virginia	1
Marquette University School of Medicine	1
Loyola University School of Medicine	3
	129

President's of the Connecticut State Medical Society From Its Organization in 1792 to the Present Time

1792 Leverett Hubbard, New Haven
1794 Eneas Munson, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1807 John R. Watrous, Colchester
1812 Mason F. Cogswell, Hartford
1822 Thomas Hubbard, New Haven
1827 Eli Todd, Hartford
1829 John S. Peters, Hebron
1832 William Buel, Litchfield
1834 Thomas Miner, Middletown
1837 Silas Fuller, Hartford
1841 Elijah Middlebrook, Trumbull
1843 Luther Ticknor, Salisbury
1846 Archibald Welch, Wethersfield
1849 George Sumner, Hartford
1851 Rufus Blakeman, Greenfield
1853 Richard Warner, Cromwell
1854 William H. Cogswell, Plainfield
1856 Benjamin H. Catlin, Meriden
1858 Alhbel Woodward, Franklin
1861 Josiah G. Beckwith, Litchfield
1863 Ebenezer K. Hunt, Hartford
1865 Nathan B. Ives, New Haven
1866 Isaac G. Porter, New London
1867 Charles Woodward, Middletown
1868 Samuel B. Beresford, Hartford
1869 Henry Bronson, New Haven
1870 Charles F. Sumner, Bolton
1871 Gurdon W. Russell, Hartford
*1872 Henry W. Buel, Litchfield
1873 Ira Hutchinson, Cromwell
1874 Lowell Holbrook, Thompson
1875 Pliny A. Jewett, New Haven
1876 Ashbel W. Barrows, Hartford
*1877 Robert Hubbard, Bridgeport
1878 Charles M. Carleton, Norwich
1879 Alfred R. Goodrich, Vernon
1880 Gideon L. Platt, Waterbury
*1881 William Deming, Litchfield
1882 William G. Brownson, New Canaan
1883 Elisha B. Nye, Middletown
1884 Benjamin N. Comings, New Britain
1885 Elijah C. Kinney, Norwich
*1886 T. Morton Hills, Willimantic
1887 Francis Bacon, New Haven
1888 George L. Porter, Bridgeport
1889 Orlando Brown, Washington
1890 Melancthon Storrs, Hartford
1891 Charles A. Lindsley, New Haven
1892 Cyrus B. Newton, Stafford
1893 Francis D. Edgerton, Middletown
1894 Francis N. Braman, New London
1895 Seth Hill, Stepney
*1896 Rienzi Robinson, Danielson
1897 Ralph S. Goodwin, Thomaston
1898 Henry P. Stearns, Hartford
1899 Charles S. Rodman, Waterbury
1900 Leonard B. Almy, Norwich
1901 John H. Grannis, Old Saybrook
1902 Gould A. Shelton, Shelton
1903 Samuel B. St. John, Hartford
*1904 William H. Carmalt, New Haven
1905 Edward H. Welch, West Winsted
Nathaniel E. Wordin, Bridgeport
*1906 William L. Higgins, South Coventry
*1907 Everett J. McKnight, Hartford
*1908 Seldom B. Overlock, Pomfret
1909 Samuel D. Gilbert, New Haven
*1910 Frank K. Hallock, Cromwell
1911 John G. Stanton, New London
*1912 E. T. Bradstreet, Meriden
*1913 D. Chester Brown, Danbury
1914 Oliver C. Smith, Hartford
Stephen J. Maher, New Haven
*1915 Max Mailhouse, New Haven
*1916 Samuel M. Garlick, Bridgeport
*1917 Edward K. Root, Hartford
*1918 Charles J. Bartlett, New Haven
*1919 Charles B. Graves, Ledyard
*1920 George Blumer, San Marino 10, Calif.
*1921 Charles C. Godfrey, Bridgeport
*1922 David R. Lyman, Wallingford
1923 Elias Pratt, Torrington
*1924 Harry B. Ferris, New Haven
*1925 Robert C. White, Willimantic
1926 Frank H. Wheeler, New Haven
1927 Daniel Sullivan, Uncasville
*1928 Earl Terry Smith, West Hartford
*1929 William F. Verdi, New Haven
1930 Frederick G. Graves, Bethlehem
1931 Charles C. Gildersleeve, Norwich
*1932 William A. LaField, Bridgeport
*John P. Hanley, Stafford Springs
1933 Ralph A. McDonnell, New Haven

*1934 Walter R. Steiner, Hartford
*1935 Thomas P. Murdock, Meriden
*1936 Daniel C. Patterson, Bridgeport
*1937 Charles H. Turkington, Litchfield
*1938 Hugh B. Campbell, Norwich
*1939 Joseph I. Linde, New Haven
*1940 Arthur B. Landry, Hartford
*1941 James D. Gold, Bridgeport
*1942 Roy L. Leak, West Hartford
*1943 George M. Smith, Branford
*1944 H. Gildersleeve Jarvis, Hartford
*1945 Joseph H. Howard, Bridgeport
*1946 Cole B. Gibson, Meriden
*1947 James R. Miller, Hartford
*1948 Samuel C. Harvey, New Haven
*1949 Charles H. Sprague, Bridgeport
*1950 Thomas J. Danaher, Torrington
*1951 Brae Rafferty, Willimantic

An effort is being made to complete a file of pictures of past presidents and photographs are available of those marked with an asterisk. Anyone having information concerning a picture of any of the others will be doing the Society a great service by communicating with the Executive Secretary's office.

Meetings Held During December

December 6—Woman's Auxiliary

December 12—Cooperation Committee—Yale School of Medicine

December 13—Committee on Public Health

December 18—Connecticut Medical Examining Board

Executive Committee, Connecticut Cancer Society

December 20—Semi-Annual Meeting of House of Delegates

Professional Education Courses

The Hartford and Bridgeport Chapters of the Connecticut Heart Association are busy with plans for courses for physicians. The Hartford Chapter has completed the second series of weekly lectures which have had an average of 100 doctors in attendance. The Bridgeport Chapter held a one day intensive seminar on December 5, 1951 featuring nine lecturers.

Yale Receives Portrait of Dr. Francis G. Blake

A portrait of Dr. Francis G. Blake, Sterling professor of medicine and former dean of the Yale Medical School, was formally presented to Yale University on November 26, 1951 at a brief ceremony in the Club Room of the Sterling Hall of Medicine. Presented by Dr. John R. Paul, professor of preventive medicine, the portrait was accepted for Yale by President A. Whitney Griswold. The portrait was a gift of over 400 former colleagues, students, friends, and members of the Medical School staff. It was painted by Raymond P. R. Neilson, a distinguished portrait painter.

This year Dr. Blake will complete his thirtieth year of service at Yale and is retiring to go to Washington where he will serve with the medical research and development program for the three U. S. armed forces. A noted authority on chemotherapy, Dr. Blake did pioneer research on many epidemic diseases including pneumonia, measles, scarlet fever, typhus and influenza. Under his direction, the Yale School of Medicine conducted experimental work with the sulfa drugs and penicillin when they were first being tested.

Dr. Blake was graduated from the Harvard Medical School in 1913. He served as a medical officer in World War I and subsequently became a member of the staff of the Rockefeller Institute for Medical Research.

In 1921 he joined the Yale Medical School faculty as a Professor of Medicine—one of the youngest men ever appointed to a full professorship at Yale. He was instrumental in raising the Yale Medical School to the front rank. In 1940 he became dean of the School of Medicine, a position he held for seven years including four in World War II. During this period, he held a number of important government positions and served as President of the Army Epidemiological Board. In this position, Dr. Blake toured Army camps throughout the U. S. and overseas. For his distinguished service during the war, he received the Medal of Merit and the U. S. Army Typhus Commission Award.

For many years Dr. Blake served as chairman of the Medical Board and physician-in-chief of the Grace-New Haven Community Hospital. He has held many positions of national importance in the field of medicine and in 1945 received the Charles V. Chapin Memorial Award.

THE HISTORIAN'S NOTE BOOK

THE STORY OF SUBCUTANEOUS MEDICATION

GEORGE BLUMER, M.D., *San Marino, California*

As Pfender* remarks in his interesting study of the development of hypodermic medication, the alleviation of pain has always been a challenge to physicians and a powerful stimulant to professional ingenuity. Until nearly the middle of the nineteenth century procedures for the relief of localized pain usually took the form of plasters or blisters near the site of its maximum intensity, the use of friction with medicated unguents to stimulate absorption of sedatives by the skin, or even the removal of areas of skin with the application of analgesic drugs to the denuded surfaces. This last method, introduced by the French physicians Lembert and Lesieur, proved too heroic and was abandoned. For a time it was succeeded by Lafargne's method of introducing powdered drugs, such as morphia, into small skin incisions. But none of these methods was satisfactory for two reasons: the relief of pain was slow, and the complications which resulted often made the remedy worse than the disease.

The use of subcutaneous medication was first introduced by one of the famous Irish school, Francis Rynd, though he came near being deprived of the credit for priority by a printer's error in a report by Alexander Wood, a Scot from Edinburgh who, probably independently, devised a similar method. In 1844 Rynd invented a cannula with a detachable needle, sometimes pushed through the skin and sometimes introduced through a small incision. The needle had an opening in its shank through which the dissolved medication was introduced into the subcutaneous tissue by gravity. The error in timing giving Wood credit for the invention was discovered by Pfender who remarked, after pointing out that Rynd was a modest man who did little to push his discovery, that "one must in a measure blow his own horn if he is to receive just recognition." Wood, in contrast to Rynd, was a persuasive and entertaining writer active in presenting and disseminating his views, and there is no doubt that he, ably aided by Charles Hunter, who coined the term hypodermic, was mainly responsible for calling to the attention of the profession the usefulness of the method. This is an old story: who deserves most credit, the man who originates a method or the man who succeeds in impressing the profession with its usefulness and "puts it on the map"?

In 1851 when the value of hypodermic medication, particularly in patients who could not tolerate opium by mouth, had been widely disseminated in England, France, Belgium, Germany and Italy by Wood and Hunter, Charles Pravaz of Lyons, France, introduced the hypodermic syringe essentially in its present form. However, the original needles were tapered and did not have the beveled points currently in use. The syringes were of either glass or metal, many preferring the former because of the visibility of the contained solution. The needles were gradually modified, first by Roberts Bartholow who, in the 1860's, introduced a lancet-shaped point and later to the present beveled model. The introduction of the hypodermic syringe into the United States was mainly due to Fordyce Barker and George Thomson Elliot.

The form of the medication used, like the trochars and syringes, gradually underwent modifications. Rynd used a solution of morphia in creosote of which six drops contained one grain of the narcotic. Later Magendie's solution, which contained two grains of morphine to the dram, was widely used but was abandoned because it was bulky, decomposed easily and often caused complicating abscesses. Still later various antiseptic substances: carbolic acid, glycerin and chloral hydrate were used as vehicles. Powders dissolved at the time of use were tried, but it was difficult to weigh small doses correctly. Finally granules and, in modern times compressed tablets, introduced by Robert Fuller of Philadelphia, came into vogue. It is evident that in the early days

*Pfender, C. A.: Washington Medical Annals, 1911-12, 19:346..

of hypodermic medication much larger doses of morphine were used than we commonly administer at present. Wood reports an instance in which he gave an old lady with cervicobrachial neuralgia, who had an idiosyncrasy to opium, two grains of morphine by Rynd's method. She was still asleep when he visited her 25 hours later and was breathing deeply. Under "energetic stimula" these symptoms disappeared and she recovered from her neuralgia.

In the early days of hypodermic medication, i.e., before the Listerian Era, the method resulted in complications galore. Between 1870 and 1900 cases of fetal tetanus, local and metastatic abscesses, cysts, bad scars, motor paralyses, pulmonary embolism, and ulnar neuritis were reported. These were, no doubt, mainly due to lack of surgical cleanliness though probably at times the result of accidental injection into a nerve or a blood vessel. While Lister introduced his antiseptic methods in 1867 it was not until many years later that they and their successors were generally adopted. Indeed in the late eighteen-eighties I saw as a medical student one of the older surgeons perform a major operation in an old frock coat liberally spotted with pus and blood stains. As experience has repeatedly shown, the medical profession as a mass tends to be ultraconservative, and it takes a long time for new methods to seep down to the average practitioner.

It would be interesting to observe the reactions of Rynd or Pravaz to the modern uses of subcutaneous and intravenous medication: the development of prophylactic subcutaneous or intravenous vaccination against infections, the administration of nutrient fluids by vein, hypodermoclysis and venoclysis, intravenous medication, the withdrawal of blood for therapeutic purposes or for diagnostic tests. All of these naturally developed from the original discoveries of Rynd and Pravaz. One may conjecture too that these observers might remark that public credulity as to the efficacy of "shots" had unfortunately led to some of these methods developing into rackets in the hands of unscrupulous practitioners.

AMA Board of Trustees Actions

FELLOWSHIP DUES ELIMINATED

Meeting at AMA headquarters recently, the Board of Trustees decided there would be no Fellowship dues for 1952. The dues, the Board felt, are no longer required since AMA members are now paying membership dues and, furthermore, the Fellowship dues requirements were too confusing to members as a whole. Fellowship dues of $5 for 1951 are still payable.

The Board re-elected Dr. Julian P. Price, Florence, S. C., to succeed himself for a term of five years on the Advisory Committee to the State Journal Advertising Bureau.

Any AMA member who plans to be in Australia during the week of August 22-30 may get in touch with Dr. Lull. He has received an invitation from the Federal Council of the British Medical Association to send a representative to the Australian Medical Congress in Melbourne at that time. The Board would like to have a representative at the Congress, provided some AMA member plans to be in that country during August.

Because of the pressure of other duties occasioned by his election as chairman of the Board of Trustees, Dr. Dwight H. Murray, Napa, California, has tendered his resignation as chairman and as a member of the AMA Committee on Legislation. His resignation was accepted and the Board of Trustees appointed Dr. J. Lafe Ludwig, Los Angeles, to succeed Dr. Murray, and Dr. Walter B. Martin of Norfolk was appointed as an additional member of the committee.

The Board authorized elimination of any charge to AMA members and to Student AMA members who make use of the AMA library lending service in the future, but increased the charge for non members to 50 cents a package for reprints and 15 cents for each journal.

The Board was informed that the AMA has initiated correspondence with the U. S. Bureau of Internal Revenue regarding a review of the 1921 ruling which denied deductions to physicians for expenses incurred in taking postgraduate courses. A report will be made to the Board and to members from time to time as the matter progresses.

Following the recommendations of the finance committee, the Board of Trustees recommended a $10,000 appropriation for the 1952 student nurses recruitment program of the Committee on Careers in Nursing. The supply of nurses for meeting essential civilian needs is short at the present time and the shortage is aggravated by heavy military requirements.

The Board named the following as additional members on the editorial board of the Archives of Internal Medicine: Hugh R. Butt, Rochester, Minn., three years; Bruce K. Wiseman, Columbus, Ohio, two years; and Louis Leiter, New York, one year.

L A CALLING

AMA Interim Session — December 4-7, 1951

Senators Taft and Byrd Blast Socialism — Other Personalities, AMA President Cline and American Legion Commander Wilson — Relation of Physicians and Hospitals — Medical Care of Veterans — Financial Support to Medical Education — Fellowship Status Abolished — Hospital Standardization — Student Medical Association — General Practitioners Award — Honorarium to AMA President — Voluntary Medical Insurance for Dependents Armed Services — Miscellaneous Actions of House of Delegates — EMIC Not Necessary — Scientific Exhibits — Technical Exhibits — Next AMA Sessions — The Future.

REGISTERED FROM CONNECTICUT

Board of Trustees: Thomas P. Murdock, Meriden.

House of Delegates: Creighton Barker, New Haven; Thomas J. Danaher, Torrington; Joseph H. Howard, Bridgeport; Stanley H. Osborn, Hartford.

Editor: Stanley B. Weld, Hartford.

Blue Shield: William Horton, Windsor.

Scientific Assembly: Tibor de Cholnoky, Greenwich; Norman H. Gardner, East Hampton; Seymour I. Kummer, Rockville; Marvin M. Scarbrough, New Haven.

Reference Committee Member, Committee on Report of Board of Trustees and Secretary: Joseph H. Howard.

With a registration of over 4,000 at the half way point, the Los Angeles Clinical Session of the AMA bade fair to break all records for the five annual interim scientific meetings. Personalities characterized the gatherings, notably Senators Taft and Byrd and Commander Donald R. Wilson of the American Legion. The House of Delegates dealt with the problem of the nonservice connected VA patient, the membership reclassification, and the relation of physicians and hospitals. History was made when television and medicine joined hands to present the first transcontinental transmission of color television. A surgical operation on the heart performed in Los Angeles County Hospital was beamed in full color to medical groups in Chicago and New York under the sponsorship of Smith Kline and French Laboratories.

TAFT AND BYRD BLAST SOCIALISM

The highlight of the Clinical Session was the appearance on the same platform of Senator Robert A. Taft, Republican, and Senator Harry F. Byrd, Democrat, before a capacity audience of 7,000. John Cline, president of AMA, in introducing the Senators pointed out that for the past three years the AMA has conducted its fight against socialized medicine on a nonpartisan basis and "has won overwhelming, nonpartisan support from all segments of the American public." Senator Taft reminded all present that socialized medicine was only the opening wedge in the door to socialism. "American liberty," he said, "is threatened by communism abroad and the growing socialism and government control at home." Taft dwelt on the subject of liberty—liberty of the individual to live and work and speak as he wishes—which is gradually being lost in the expansion of government control. He pointed out that the government has an obligation to relieve hardship and distress where private charity cannot do it. "If we don't want charity to develop into socialism, however, there must be State and local control, and the service must under no circumstances be federalized."

Senator Harry F. Byrd brought to his medical friends the pleasing countenance and gracious manner of the Southern gentleman. He said, "they wonder what kind of a Democrat I am. A survey has shown that I voted 66 times with the Republicans and 34 times with the Democrats. The truth of the matter is, my name comes near the beginning of the alphabet. I vote first and the Republicans vote with me." Truman the tax collector and Truman the spendthrift were ably described by Senator Byrd. Speaking of socialized medicine, he said, "the cost of socialized medicine in America is difficult to estimate. We do things on a very grandiose scale when it comes to spending money. Some of the statisticians have estimated the ultimate cost at $20 billion annually, and in 50 years that amounts to $1 trillion." . . . "There are many doors to the house of socialism. It is very easy to get in but very hard to get out. Let us not be led into socialism by the back door."

This program was broadcast coast to coast over ABC and was televised locally. Both senators received an uproarious welcome; the applause was frequent and loud.

OTHER PERSONALITIES: CLINE AND WILSON

President John W. Cline was dynamic in his address before the House of Delegates at its opening session. Some of the points he made were: AMA has a budget now of $9 million—more than 77 million Americans have coverage of some form against illness—about 22 million have Blue Shield contracts—about 44 million are enrolled in Blue Cross—the medical profession never again should be placed on the defensive—organized medicine continues to oppose federal aid to medical schools and to encourage voluntary aid through the American Medical Education Foundation—the only important item in the rising cost of medical care is the per diem hospital charge, 60 to 70 per cent of which is due to increased labor costs—our public relations as a profession are enhanced by good grievance committees in every State and county to deal with the chiseler and unethical physician, by central telephone exchanges, by a closer cooperation with civic, labor, and industrial groups, by support of the Woman's Auxiliary.

The American Legion is now headed by a veteran of World War II, Donald R. Wilson of Clarksburg, West Virginia. He made an excellent impression on the House and was given a great hand as in a clear, ringing voice he announced that "no organization is more determined to have the genius of the American doctor unshackled by any form of socialism of American medicine (than is the American Legion). It is our firm and unalterable belief," he continued, "that the American doctor, when left to his own inspired resources, will provide the basic answers to the problems of medical care which face not only the American veteran, but also the American people at large."

RELATION OF PHYSICIANS AND HOSPITALS

For the past two and one half years this problem has been before the House of Delegates at every session. It culminated in the famous "Hess Report" which pronounced the employment of physicians by hospitals on a fulltime basis as unethical. The pot has continued to boil and only the froth has been skimmed off from time to time. Explosions of minor extent have occurred from Boston to Los Angeles and the problem still remains a problem. The Board of Trustees of the AMA has been studying during the past year all the reports issued on this subject by the various committees and councils. To clarify the atmosphere the Trustees have come out with a statement which is to be substituted for all these reports. Entitled "Guides for Conduct of Physicians in Relationships with Institutions," it will be found printed in full on page 35, this issue of the JOURNAL. In essence, it calls attention to the fact that the first obligation of both physicians and hospitals is to serve the best interest of the patients. The question of ethics in medical practice must depend on the effect on the public. The many problems involved between physicians and hospitals must be solved at the local level. These problems have been aggravated by medical services included in Blue Cross contracts. The recognition of the voice of the professional staff by the governing lay body of any hospital and the interest of the physicians in the economic problems of a given hospital management are essential. No hospital should dispose of a physician's professional services for a fee. The practice of radiology, pathology, anesthesiology and physiatry are just as much a part of medicine as are surgery and obstetrics.

MEDICAL CARE OF VETERANS

The medical care of veterans with nonservice connected disabilities is still a hot subject. Resolutions were brought into the House condemning the care of such veterans in VA hospitals. The Tennessee delegation has been ardent in advocating for several years now that the federal government purchase insurance policies for the benefit of dependents of veterans with nonservice connected disabilities who are financially unable to purchase such themselves, in order that such may be cared for in civilian hospitals. Vice-Admiral Boone, chief medical director of VA, pointed out certain facts which would make such legislation explosive. 152 hospitals out of 174 in the VA program now are caring for 103,000 patients. About 50,000 of these are neuropsychiatric, 16,000 tuberculous, and 35,000 are general. Under any procedure the NP and TB patients would become government charges. Many civilian hospitals are chary of accepting patients with chronic ailments or disabilities. The paraplegics would have no place to go if not cared for by VA. The veterans organizations are watching the possible exclusion of chronic cases from VA hospitals. In spite of the opposition to caring for veterans with nonservice connected disabilities in VA hospitals by many physicians, Admiral Boone pointed out that many of

those same doctors are themselves sending such cases to VA.

Committees have been appointed and investigations ordered by the House of Delegates in the past but very little has been accomplished. Now the House has voted that the Board of Trustees appoint a special committee to study the entire problem and secure the assistance of other organizations involved and report back to the House at its next meeting in June 1952.

FINANCIAL SUPPORT TO MEDICAL EDUCATION

The House of Delegates continues to oppose federal aid to medical schools on the ground that it will provide the government with another toehold. In place of this the Board of Trustees is urging every physician to support the American Medical Education Foundation. Up to November 30, 1951, $266,784.85 had been contributed to this fund by physicians, far short of the $1 million that it was hoped would come in. With 140,000 members of the AMA this is a very poor showing. In three States not a single physician has contributed. Recently the American Society of Anesthesiology made a gift of $2,500. This fund is to be channeled through the National Fund for Medical Education headed by Hon. Herbert Hoover and allocated to the 79 medical schools. As of October 1, 1951 the total contributions to the Foundation were $689,244.90. This amount provided for more than 50 per cent of the initial grants made by the National Fund to the medical schools in July 1951. Donations to the Foundation may be earmarked for the benefit of any approved medical school the donor desires. The Board of Trustees has appropriated $500,000 to the Foundation for 1952. Every physician is urged to contribute something.

FELLOWSHIP STATUS TO BE ABOLISHED

The Standing Committe on Constitution and Bylaws has recommended several important changes in membership which must lie over until the meeting of the House of Delegates in June 1952. Fellowship would be abolished and there would be the following categories of membership: (1) Active; (2) Service; (3) Associate. This means that there will no longer be any Fellowship dues. At the Los Angeles session the delinquency date for payment of dues in any one year was moved back from December 31 to June 1 to aid the secretary in making up the membership roster. A provision was also voted whereby members may become exempt from payment of AMA dues on January 1 following their 70th birthday, regardless of local dues exemption.

HOSPITAL STANDARDIZATION

The Joint Commission for the Accreditation of Hospitals has now been approved by the four participating organizations—AMA, American Hospital Association, American College of Physicians, and American College of Surgeons—and is ready to start work. The AMA has six members on this commission, two elected for three years, two for two years, and two for one year. The Joint Commission will be the final authority for the accreditation of hospitals, carrying out the standardization program previously sponsored by the American College of Surgeons.

The Council on Medical Education and Hospitals has published a revision of its "Essentials of an Acceptable Medical School." The number of hospitals approved for residency training in 1950 was 1,071, in 1951, 1,120. Residency programs in general practice increased from 32 in 1950 to 66 in 1951. Foreign medical schools acceptable on the same basis as medical schools in the United States have been increased from 38 to 49.

STUDENT MEDICAL ASSOCIATION

Forty-one out of 79 medical schools now have Student Medical Association chapters. These charter members represent more than 1,400 students. Since September, 20 schools have taken preliminary steps to establish chapters. The Student AMA now has two delegates who sit in as observers at the sessions of the House.

GENERAL PRACTITIONER AWARD

The AMA gold medal award for outstanding service to his community was bestowed on an 84 year old Indiana general practitioner, Dr. A. C. Yoder. A graduate of Rush Medical College, Dr. Yoder has practiced in Goshen, Indiana since 1902. He has been president of his county association twice and for 35 years a delegate to the Indiana State Association. Defeated candidates for the honor were Dr. Everett B. Lattimore of Shelby, N. C., and Dr. Clayton Willison of Sault Ste. Marie, Michigan.

HONORARIUM TO AMA PRESIDENT

The House of Delegates voted to pay the president and president-elect an honorarium in addition to their expenses, this amount to be between $5,000 and $10,000 and to be determined by the Board of Trustees.

VOLUNTARY MEDICAL INSURANCE FOR DEPENDENTS OF ARMED SERVICES

The House also approved the care of dependents of the armed services by physicians through Blue Shield and medical society sponsored plans.

MISCELLANEOUS ACTIONS OF HOUSE OF DELEGATES

Fluoridation of water supplies was approved. The augmentation of the Washington Office by the purchase of property by the Board of Trustees at the proper time was also approved. Action against the teaching of collectivism in public schools was taken. Expression of disapproval was voiced on deferment of chiropractors from armed services. Cancellation of 1950 AMA dues was left to the General Secretary to negotiate. The necessity for high priority for materials to be utilized for the construction of hospitals and health facilities was voiced. The deplorable teaching programs of dermatology and syphilology in some medical schools was referred to the Council on Medical Education and Hospitals for action. The House approved an investigation of the problems of the older worker. The term of office of members of the Board of Trustees is limited to 10 years and this also is to apply to members of all standing committees. The need for replacement of blood in banks for each pint expended was pointed out and physicians urged to make it their job to see that such replacements are made. The plan of the Board of Trustees to take steps to warn parents of children against dangerous household drugs not labelled poison was approved. The House approved the opinion of the Judicial Council that expenditures for the entertainment of guests is an ethical deduction for income tax purposes.

EMIC NOT NECESSARY AGAIN

The Council on Medical Service reports that, after a careful study and several conferences with representatives of many groups, it has found all groups with one exception of the opinion that there is no widespread need for a reinstatement of a program such as World War II EMIC. Further study is necessary, however, to answer many correlated questions.

THE SCIENTIFIC EXHIBITS

The accommodations for the scientific and technical exhibits as well as for the meetings of the scientific sessions at the Shrine Convention Hall were impressive. Cool and comfortable, the hall lent itself to an enjoyable tour through its aisles and corridors. Crowding existed in the colored television space, but considering the newness of this feature it was not surprising. By the way, it was a good show although the colors seemed a bit overdrawn but this is excusable at this early date. The movies were popular as usual and Henry Viets of Boston with his efficient committee arranged an excellent program of lectures, pointed for the benefit of the G.P. Crowded also was the obstetrical manikin demonstration space, the mechanical quackery and the leg pain exhibits.

Considerable space was afforded the subject of obesity. The Metropolitan Life Insurance Company presented facts on mortality and morbidity among overweights based on recent life insurance and clinical experience that were good. Singled out in particular as affected by obesity were hypertension, diabetes, cancer of cervix and endometrium, pregnancy, asthma, bronchitis, gall bladder disease, and degenerative cardiovascular disease.

A group from the Institute of Medical Research in Oakland had an excellent exhibit on the "Use of ACTH and Cortisone in Medical and Surgical Emergencies." Emphasis was placed on the use of these steroids, together with adequate chemotherapy, in the presence of actual or potentially infectious conditions.

Methods of artificial respiration were vividly displayed by the use of 24 wooden manikins. Pneumograms were also used to depict the ventilatory pattern and volume of each of the methods.

Henry Jaffe of Cedars of Lebanon Hospital and U.S.C. School of Medicine had an excellent exhibit showing how radioactive iodine is used in tracer doses for the diagnoses of thyroid disease and of brain tumors. Also was demonstrated the use of radioactive iodine therapeutically, and the use of radioactive phosphorus in a variety of diseases.

The Council on Physical Medicine with other councils and committees presented an excellent exhibit showing the effect of noise on health. This included information on noise in physicians' offices, hospitals and operating rooms.

A model pressurized aircraft C-54 demonstrated the modern method of evacuation of the wounded by the U. S. Air Force.

TECHNICAL EXHIBITS

One was impressed in perusing the technical exhibits by the number of firms demonstrating x-ray apparatus as well as other forms of highly special-

ized medical and surgical techniques. This the more noticeable since this interim session is particularly planned for the benefit of the general practitioner. However, Ethicon had its Western cowboy ranch and Sealy Mattress Company its sample being pounded hour after hour by a huge roller. Then, too, Old Gold was giving away yellow carnations carrying an attached Old Gold flyer; Coca-Cola, Seven-Up and Pepsi-Cola were administering to the thirst of their customers; Loma Linda Food Company, Kellogg and Beech Nut all proffered small appetizers; and from Kool Cigarettes one might be fortunate enough to receive a penguin for the baby along with a package of cigarettes, or from Vaisey-Bristol Shoe Company a plastic savings bank in the form of a shoe suitable for any member of the family who has difficulty saving these days. Oh yes, I almost forgot the pack of cards that blonde nurse representing Anne Alt brassieres slipped into my hand after I had shown a rather discriminating interest in the product and the live model on hand. The American Medical Association sponsored several good exhibits on this floor as well as on the Scientific Exhibit floor, not least among them being a display of the State Medical Journals. Connecticut JOURNAL with its red border could not be missed.

NEXT AMA SESSIONS

Los Angeles proved an excellent host, hotel accommodations were good—I heard no one kicking except one New Englander who wished he had brought his entire family, his room was so large. The House of Delegates despatched its business with a commendable speed and a minimum of open controversy, thanks to the efficient work of the reference committees. A variety of weather kept one guessing and more than once could be seen a raised eyebrow, particularly from the Floridians, when one ventured to extol the climate of Southern California. It was not always warm and sunny, but the view of the snow capped Sierras rising behind the city on one of those better days, with the sun reflected on steeple and tower over the vast city to the Pacific beyond was recompense enough.

1952 calls for the Annual Session in Chicago, June 9-13, and the Clinical Session in Denver, December 2-5. In 1953 the AMA will move to New York City for its Annual Session, June 1-5, in conjunction with the tercentenary of the County of New York and to St. Louis, December 1-4 for the Clinical Session. Back west in 1954 to San Francisco for the Annual Session, June 21-25, and then South to Miami for the Clinical Session, November 30 - December 3.

THE FUTURE

The AMA is on the march. In the words of its president, John W. Cline: "The future freedom of medicine and the future of our country depend upon the events of the coming year. Let it not be said that we who clearly see the importance of this decision (to stop the progress toward socialism) were in default of our duties as physicians and citizens."

RELATION OF PHYSICIANS AND HOSPITALS

Pronouncement from Board of Trustees, AMA, adopted by House of Delegates at Los Angeles Session, December 6, 1951.

On June 9, 1949 the House of Delegates approved a Report of the Committee on Hospitals and the Practice of Medicine as revised by the Reference Committee; in December 1949 the House by motion reaffirmed the principles of such report but re-referred it to the original committee for revision; in June 1950 the House of Delegates approved, as amended by the Reference Committee, the further report of the Committee on Hospitals and the Practice of Medicine and in December 1950 an Addendum to such report recommended by the Judicial Council.

The Board of Trustees has had these reports under study for the past year and is of the opinion that they need clarification. Accordingly, the Board of Trustees recommends that there be substituted for all those reports referred to in the first paragraph hereof the following statement to be known as:

GUIDES FOR CONDUCT OF PHYSICIANS IN RELATIONSHIPS WITH INSTITUTIONS

So far as it can be determined on the basis of study made by the Bureau of Legal Medicine and Legislation of the American Medical Association, as a

matter of law the corporate practice of medicine is illegal in most states. In almost all instances the classic example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a professional man and then sells his services to the public on a fee basis for the profit of the corporation. Such exceptions as there are refer to statutory legislation in several States permitting certain modifications of this general law. It must also be remembered that fee splitting with a corporation is just as unethical as fee splitting with another physician.

In addition to being guided by the laws of the various States, physicians in their relationships with hospitals must be guided by the Principles of Medical Ethics of the American Medical Association. Those sections of the Principles which have a distinct bearing on these relationships are as follows:

Chapter I, Sec. 3. "Groups and Clinics—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession."

Chapter III. Article VI. Sec. 2. "Conditions of Medical Practice—A physician should not dispose of his service under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediate necessary care."

Chapter III. Article VI. Sec. 3. "Contract Practice—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

"Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered."

Chapter III. Article VI. Sec. 6. "Purveyal of Medical Service—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

In conclusion, the Principles of Medical Ethics states: "These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community . . ."

On page 31 of the Constitution and By-Laws as printed in the Handbook under Duties of the Judicial Council, is found the following:

"The Council shall have jurisdiction on all questions of medical ethics and the interpretation of the laws of the Association.

"The Council at its discretion may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

"The Council shall have authority to request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused."

The primary obligation of both physicians and hospitals is to serve the best interest of the patients. The decision as to the ethical or unethical nature of practice must be based on the ultimate effect for good or ill on the public as a whole. All of the various questions involved in the relationship between physicians and hospitals, both legal and ethical, particularly questions dependent on local conditions, must be considered in the first instance at the local

level because of the various differences which of necessity exist in the many sections of the country.

One of the factors that have aggravated physician-hospital relationship is the inclusion of medical services in the contracts of voluntary hospital service plans. The medical profession is fostering voluntary health insurance, and we believe that nothing should be done to disturb this very important and essential program. However, the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council, and the House of Delegates the principle that hospital service plans should exclude all medical services, and the contract provisions of such plans should be limited exclusively to hospital services. At the same time, so that there would be no misunderstanding as to which services should or should not be included, the House of Delegates has stated that ". . . if hospital service is limited to include only hospital room accomodations, such as bed, board, operating room, medicine, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear." (Proceedings of the San Francisco Session of the House of Delegates, 1938, p. 31). Past actions of the House of Delegates give every reason to reiterate that radiology, anesthesiology, pathology and physiatry constitute the practice of medicine.

In order to initiate a method for remedying this situation, it is recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services. It is hoped that the professional and hospital authorities and the voluntary prepayment plans will cooperate in furthering these recommendations.

Since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its board of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, among them adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for professional work. Unfortunately, in many instances, the financial problems of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong and probably the cause of most of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems if the hospital is to work efficiently and remain the workshop of the physician, and without proper facilities the services rendered to the public are in jeopardy and these public services are the all important function of both hospital and staff.

Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and physiatrist, as well as the other professional staff members, should have equal standing as active members of the staff with all the rights and privileges pertaining to other members of the staff of equal standing. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the same hospital.

The revised Principles of Medical Ethics has been written with all of these various factors in mind and is broad enough to cover all possible ethical physician-hospital relationships. The Constitution and By-Laws of the American Medical Association distinctly covers methods of procedure for all persons who have a complaint so that they may approach the Judicial Council. The functions of that Council are specifically delineated.

In the event of a controversy between physician and physician, or physician and hospital management, on these problems, it is recommended that, since local conditions must be taken into consideration, these problems be resolved insofar as possible at the local level.

There can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to

supply the greatest possible good quality medical and hospital services to the public. In any given controversy, every effort should first be made to settle the matter at the staff-management level. In case of failure to settle the controversy at this level, assistance of the county medical society should be requested. If, then, it cannot be resolved it should be submitted to a committee of the state medical association for advice and recommendation. If problems cannot be solved at the staff-management level, through the county medical society, or through the state medical association, the Constitution and By-Laws of the American Medical Association provides that ". . . the (Judicial) Council, at its discretion, may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary."

To implement the settlement of such controversies, it is recommended that each component medical society and each constituent state and territorial medical association appoint a Committee on Hospital and Professional Relations. This committee should be available to receive complaints from any physician, hospital, medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals. On receipt of such complaint by such a committee the matter should be investigated and acted on in such manner as will best effect adjustment of the complaint.

Another approach that should not be neglected in activating this report is that of the local and state hospital associations. Most of the States and many communities have hospital associations providing direct representation for the hospitals within their areas. It seems reasonable to assume that state medical associations and component county medical societies could well effect liaison with these organizations in the settlement of problems involving physician relationships.

In summary, the following general principles are suggested to individual physicians, county medical societies, and state medical associations as a basis for adjusting controversies, these principles, however, to be qualified to the extent required by the applicability of one or more of the factors heretofore mentioned:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine. (28-30) (44) (45) (52).

Report Gains in School Health Programs

School health programs are gaining momentum throughout the United States, it was reported at the Third National Conference on Physicians and Schools, held in the Moraine Hotel, Highland Park, Illinois, November 6-8. The conference, sponsored by the Bureau of Health Education of the American Medical Association, was participated in by approximately 200 educators, physicians and public health officials from 36 states, the District of Columbia, Hawaii, Japan and Israel.

Dr. W. W. Bauer of Chicago, director of the bureau, pointed out that the purpose of the conference was to develop cooperative and effective health services for school children. Dr. Bauer, however, called for an objective appraisal of the situation, saying that it had become fashionable to exaggerate existing evils and to magnify deficiencies.

"Seldom is one willing to admit that there is anything good about the health situation in the United States," he said.

Some method of assuring needed medical care of school children has been developed in four out of five communities, based on reports of 1,003 local medical societies, Dr. Donald A. Dukelow of Chicago, medical consultant of the bureau, said.

"Established methods of arranging treatment for eligible children other than through public funds were reported by 56 per cent of those returning questionnaires sent out by the bureau," Dr. Dukelow added.

"In a considerable proportion, services contributed without charge by private physicians were a means of giving such children necessary help."

Approximately three out of four communities reported that teachers carry out rough screening procedures and that more than one half of the teachers have training in observation and screening techniques, he said.

Joint action at state and local levels between health departments, departments of education, and medical societies is in general the most feasible method of developing school health services, according to Fred V. Hein, PH.D., of Chicago, health education consultant for the bureau.

"Community understanding and appreciation of school health services must precede or accompany their development," Dr. Hein said. "All those concerned in the program share responsibility for this education."

Warren Southworth, DR.P.H., associate professor of health education at the University of Wisconsin, Madison, said broader arrangements for first aid care of pupils should be made in schools.

Health is a fundamental factor in training and preparation for citizenship, said Dr. A. O. DeWeese of Kent, Ohio, secretary of the American School Health Association.

Medical progress has brought about less rigid quarantine measures, Dr. C. Morley Sellery of Los Angeles, director of the Los Angeles City Board of Education's health services branch, told the conference.

Schools should help parents see the need of health service for their children, according to Clyde Parker, M.A., superintendent of schools of Cedar Rapids, Iowa.

The doctor's function in the schools is to conduct preventive services for the benefit of all pupils; caring for sick children is the responsibility of the parents and the physicians serving the child and his family, in the opinion of Dr. Carl A. Wilzbach, Cincinnati's commissioner of health.

The participants in the conference were divided into five discussion groups, covering every phase of the school child's health. Each division made a report, which was adopted by the conference. Several emphasized the importance of having the family doctor conduct the health examinations of school children where possible.

Leo E. Brown of Chicago, assistant to the general manager and director of public relations for the AMA, stressed that in order to develop effective school health programs the participants would have to carry out the recommendations at local levels.

One working group under the chairmanship of Miss Marie Swanson of New York, school nursing consultant of the National Organization for Public Health Nursing, considered follow-up methods to meet the health needs of a school child.

The group stressed the importance of effective use of available health facilities for correction or alleviation of the health problems of children of school age and pointed out that health examinations have limited value unless an organized program of follow-up is established.

"Such a program encourages rather than replaces parental responsibility," the group's report said.

"Follow-up must be preceded by the use of various measures for discovering individual health problems, such as health examinations by family or school physicians and dentists, as well as teacher observation, nurse-teacher conferences and other screening procedures. It involves measures to encourage parents to secure all needed diagnostic services and medical and dental treatment, and arrangements for educational and other adjustments of the child in the family, school and community.

"The first step of a follow-up is the creation of a favorable attitude on the part of the child towards his own health. It also involves helping parents, teachers and all other persons concerned with the health of children to appreciate and fulfill their individual responsibilities. Properly performed, follow-up helps develop an understanding of the value of continued health care throughout life."

Health services in physical education, including athletics, were considered by a group, of which the chairman was Vaughn Blanchard, M.P.H., of Detroit, Michigan, director of health and physical education in Detroit public schools. The participants reported a marked variance in conditions and practices in different schools and in different sections of the country.

The group's conclusion was that interscholastic athletic competition presents abundant opportunities

for the improvement of or harm to the health of those taking part. Accordingly, it recommended that coaches should be adequately prepared in: (1) principles of growth and development; (2) health needs of adolescent boys and girls; (3) desirable health practices, particularly those related to the conduct of athletics; (4) principles of first-aid and accident prevention; (5) physiology of exercise; (6) conduct of interscholastic athletics so their maximum contribution may be made to the physical, emotional, mental and social development of youth.

It also was pointed out that "deplorable sanitary conditions" existed in some physical education plants and that unsatisfactory practices have gone along with participation in activities. The group held that study of this problem was one of the most important projects which faces those interested in school health.

"The fact that home sanitary conditions are frequently far from satisfactory is a good reason why education in this area is important and improved conditions mandatory," it said.

New concepts in control of communicable diseases were discussed by a group of which the chairman was Dr. Carl Neupert of Madison, Wisconsin, state health officer for the State of Wisconsin. The group stressed the need for prompt recognition of what might be an acute communicable disease.

"To enable the teacher to carry out this responsibility she should have adequate instruction in her teacher training with ample opportunity to put the knowledge to use in practice teaching," it reported.

"She should have the opportunity to observe children where this is practicable. Teachers who have not had this as a part of their preparation for teaching should be provided with in-service training as the best substitute.

"For best results there is need for interprofessional understanding and cooperation between teachers, nurses, practicing physicians and public health people."

A group headed by Dr. Carl Wilzbach of Cincinnati, Ohio, Commissioner of Health of Cincinnati, urged the development, with medical society cooperation, of a written plan for handling individual and group accident or illness emergencies.

It also suggested that there should be at least one first aider on every faculty, with the aim of having a large percentage of all employees familiar with simple first aid procedures.

The group recommended the adoption of an emergency record system covering each pupil so as to permit rapid action, including the notification of parents, in the event of an accident. Records of accidents, it said, also should be kept for use in planning protection and preventive measures.

Schools, it also was pointed out, should cooperate with local and state officers in the planning of a civil disaster program.

Teacher colleges should require all teachers to have suitable courses in health education, in the opinion of one working group, of which the chairman was Simon McNeeley, M.A., of Washington, health and physical education specialist to the Office of Education of the Federal Security Agency.

"These courses should be given in a functional manner so that the student teachers will have an opportunity to conduct health observation and screening tests on pupils," the group reported.

It pointed out that some state certifying boards already require such courses for a teaching certificate. However, it stressed that physicians, communities and school administrators must recognize the importance of the teacher's role in health appraisal if conditions in some schools are to be improved.

The group's report also said that in the cities or states with successful school health programs, medical societies were actively brought into the project.

Blood Collections Increasing

Blood collections during October 1951 were reported by the Connecticut Regional Blood Program as greater than in any previous month. During the first week of November an average of 524 pints of blood was donated each day, and 848 pints were sent to laboratories for processing into plasma as compared to 411 pints during the entire month of September.

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Members Who Have Entered Military Service

1st Lt. Pasquale J. Amico (formerly of Greenwich)
Officers Mail Section
Fitzsimons Army Hospital
Denver 8, Colorado

1st Lt. Herbert Herr, USAF (formerly of Guilford)
136th Fighter Interceptor Sqdn.
Niagara Falls Municipal Airport
Niagara Falls, New York

1st Lt. Robert D. Murphy, USAF (formerly of Wethersfield)
151st ACTW Group
Camp Edwards, Falmouth, Mass.

New Doctor Draft Interpretations

In an information bulletin, the National Advisory Committee to Selective Service makes the following points:

1. When delay in active duty is requested for a Naval reserve medical officer, the request must be signed by the State chairman and must clearly state that the officer is essential in his present capacity.

2. World War II deferment of medical students, resulting in their being placed in Doctor-Draft Priorities I or II, must have taken place in part at least within the period December 7, 1941 to March 31, 1947.

3. The Doctor-Draft act applies only to World War II deferments granted by the Selective Service System, and not to active duty deferments granted to reserve officers by the military services. Therefore, a registrant who received deferment under the latter conditions is not by reason of this to be placed in Priorities I or II.

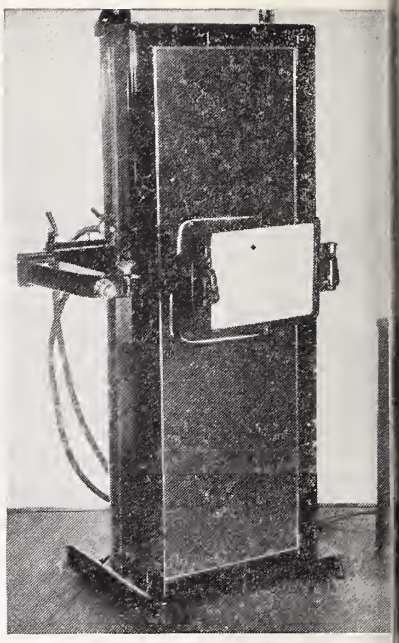
Guidance For New Graduates

Rusk medical advisory committee to Selective Service is sending a special bulletin to all State advisory groups on subject of recent medical graduates under 26 years of age. These young men are subject to regular draft law as well as to "doctor draft." As special registrants under latter's provisions, they go into Priority III. State medical advisors are being advised to request deferment for them until they complete their internships. When that time comes, they will be urged to apply for commissions and request immediate active duty. "They will thus," says Rusk committee bulletin, "be given the opportunity of serving their 24 months at a convenient time in their professional careers rather than at some future date, less convenient, prior to the advent of their 35th birthday."

One Out of Four Priority I Physicians On Active Duty

Latest compilation at Selective Service headquarters reveals that, as of October 31, slightly more than one-fourth of all special registrants (physicians) in Priority I were on active duty in armed forces. Registrant total was 10,732, of whom 2,767 were currently in uniform. Almost as many (2,686) held Reserve commissions but were on inactive list. Deferred on grounds of essentiality were 1,595, while nearly one-fifth of all Priority I registrants (2,024) held 4-F deferment status. Corresponding figures for Priority I dentists: Total registered, 3,925; on active duty, 1,099; commissioned but on inactive duty, 1,099; deferred for essentiality, 285; 4-F, 561.

In Priority II, physician registrants total 2,550, of whom 250 are on active duty; 477 commissioned but inactive, 635 deferred for essentiality; 398 in 4-F. For dentists in Priority II, respective figures are: 727; 133; 144; 82 and 137. Except for shortages in some specialties, medical personnel situation in armed forces is fairly satisfactory. No call-ups for induction are foreseeable, though Army is combing Priority I roster for orthopedic surgeons, radiologists and EENT's who can be induced to volunteer for active duty.



when you are looking

. . . for dependable service
and a complete line of medical
equipment — call

American Surgical

Available —to you —

X-ray servicing on all types of Equipment.

Radiographic Technique Instruction.

Repair of Equipment.

Installation.

md ECO

of floor space, provides both radiogr
fluoroscopic facilities in a smartly
and compact unit.

Available in four distintinctive execu
apparatus may be purchased in 15, 30.
milliampere capacities commensurate
requirements of your practice. Wher
cated, the power of the Economy M
be increased by interchangeable com

American Surgical

SUPPLY AND EQUIPMENT COMPANY : 1715 BARNUM AVE.

the COMBINATION FLUOROSCOPE

The Combination Fluoroscope extends beyond the operating sphere of the normal fluoroscope and through a pivoting arm which suspends the tubehead—brings the added facility of horizontal as well as vertical radiography to the operator. The unit is completely shockproof and provides ample maneuverability for all general x-ray examinations.

Like others in the Economy Series, the Combination Unit is available in four types.

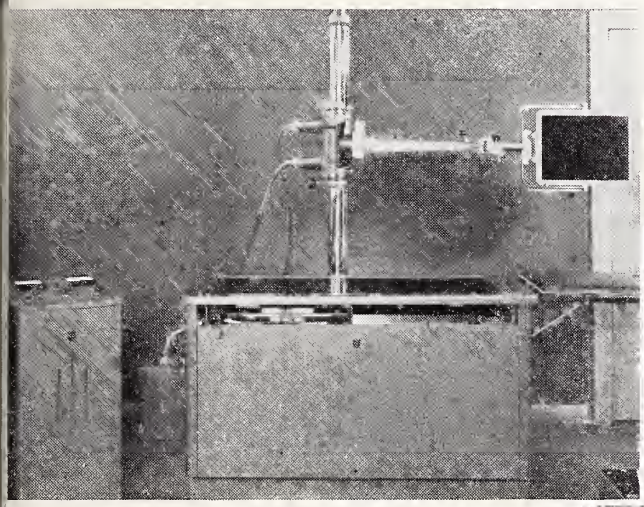
Self-contained generators are available with either 15 or 30 milliampere output, rated as follows:

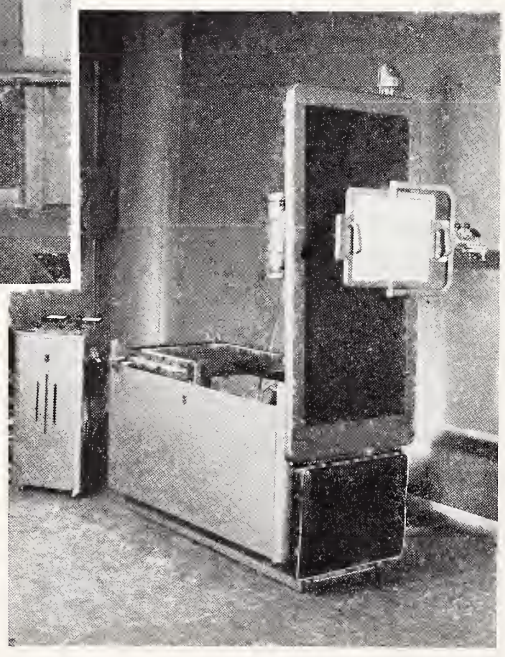
15 MA at 80 KVP or 30 MA at 90 KVP
5 MA at 80 KVP or 5 MA at 80 KVP

The self-contained head may be replaced by a cable connected x-ray tube and high-tension transformer for increased energy ratings as follows:

50 MA at 85 KVP or 100 MA at 85 KVP

Maximum height overall	80 inches
Maximum width overall—arm extended	53 inches
Maximum extension of tube—over table	23 inches
Vertical travel of screen and tube (max.)	53 inches
Horizontal travel of tube	9 inches





Y MASTER, requiring a minimum

The Economy Master table is one which may be used in the doctor's office for general utility or as an examining table. In the Economy Series, newest addition to the North American Phillips line, apparatus operation has been greatly simplified requiring least possible effort on the part of the operator. Changeover from horizontal to vertical position for either fluoroscopy or radiography can be accomplished in a moment.

If you wish our representative to call PHONE 5-3116 or ENTERPRISE 3190 . . . or fill in the inquiry slip and mail it today.

The American Surgical Supply and Equipment Co.
Bridgeport, Conn.

Gentlemen: Kindly have your representative call on

Date..... Time.....

I am interested in: Combination Fluoroscope ☐ Economy Master ☐

Dr. .....

Address .....

.....

BOX 150 : BRIDGEPORT

Medical ROTC's Benefit by Army Air Force Interchange

Approved in November by Army and Air Force medical departments was an agreement designed to benefit medical students enrolled in ROTC units. Since 48 of the nation's 72 four year medical schools have such units, with which some 5,000 students are affiliated, it is apparent that the change has some significance. It is this: Henceforward, advanced ROTC's (3rd and 4th year students) will be permitted to apply for Air Force sponsored military internship, even though they previously had given Army as their choice of service. Conversely, they may now pick Army though their original choice was Air Force. Rule's inflexibility heretofore has been a sore spot and the agreement achieved last week should please a great many ROTC students and their instructors.

For fiscal year 1953, beginning next July 1, Army will provide 150 internship spaces in its hospitals and Air Force will offer 60. (Latter is exclusive of internships in civilian hospitals, still offered by Air Force but not by Army or Navy.)

Defense Department Delayed December Call on Selective Service for Doctors

Defense Department announced postponement of its scheduled December call on Selective Service for physicians—the fifth straight month the Armed Forces have been able to meet their requirements from reserves without asking for drafted doctors. The Department was authorized to ask Selective Service to draft doctors for three months, July, August and September. Only the July call actually was invoked, but volunteers came into the reserves in such numbers in July that only two men actually had to be drafted. Subsequently, the reserve rolls continued well filled, and each monthly call was postponed. However, there has been no change in the legal situation, and Defense Department may at any time turn to the draft. There is a possibility this will have to be resorted to at some time next year, when large numbers of young medical officers will have completed their two years of service.

Medical School Scholarships Endorsed

Medical school scholarships, advanced by Army Surgeon General's Office and approved at recent meetings of deans, has now been endorsed in principle by Armed Forces Medical Policy Council which will investigate the feasability of expanding the plan to dental and veterinary and possibly nursing schools. Also the plan may be adopted by the Navy and the Air Force.

Rosenberg Reply to Senator On Dependent Care Revealed

Substance of Assistant Secretary of Defense Anna M. Rosenberg's reply to a letter from Senator Lister Hill (D, Alabama) sheds some light on Pentagon approach to the question of medical-hospital benefits for servicemen's dependents but leaves several informational gaps. Hill's letter propounded nearly 30 questions. Mrs. Rosenberg, in response, informed him: Military services will continue to hospitalize dependents, provided beds are available, even in areas where civilian facilities are adequate; in future construction of military hospitals, about 13 per cent of new beds will be informally earmarked for occupancy by dependents, which is roughly the same ratio on inpatient rolls today; average cost per patient day in Army, Navy and Air Force hospitals is $13; anticipated cost of new hospital construction will average $17,783 per bed; no doctors will be drafted or otherwise procured specifically for assignment to care of dependents; Department of Defense does not, as general policy, encourage military personnel to enroll dependents in voluntary medical or hospital care plans and has no idea how many servicemen's families are so protected.

VA Rules 2-Year Psychosis Presumption For All

After more than a month's study of the situation, Veterans Administration has made its final ruling and issued regulations on PL239, this Congress. It has decided that all World War II veterans and men in service since start of Korean war developing psychosis within two years after separation will be considered service connected for purposes of hospitalization and outpatient care. Because law made no mention of cause of psychosis, VA ruled all men, even those whose disability was obviously not due to service, will be considered service connected. This means that at least 9,000 patients awaiting VA hospitalization are service connected cases and VA is faced with an acute bed problem. Some patients will be sent to private and State institutions and a few will require only outpatient care but VA will have to give these NP cases priority as its own beds empty.

NEWS FROM WASHINGTON

Congressional Activity in Brief

During the first session of the 82nd Congress 9,615 legislative measures were introduced. All of these we screened for medical implication.

Bills enacted into law were:

S1—Extension of Selective Service—Became Public Law 51.

S349—Defense Housing and Community Facilities—Became Public Law 139.

SJ.Res.72—Medical, hospital, compensation, and pension benefits for Korean veterans—Became Public Law 28.

HR3193—$120 pension for nonservice connected disabled veterans requiring fulltime attendants at home—Became Public Law 149 (passed over President's veto).

HR3298—Prescription Drug Bill—Became Public Law 215.

Important bills which have been passed by one of the two Houses of Congress and could be acted upon by the other House next year are:

S445—Local Public Health Units—Passed by the Senate. The House Interstate and Foreign Commerce Committee held hearings on companion bill, HR274, but took no other action.

HR5426—To rewrite the law concerning the reserve components of the military services—Passed the House but was not acted upon by the Senate before adjournment.

Other important pending legislation to be considered next year:

S337—Federal Aid to Medical Education—On October 3, 1951, following the defeat of the first committee amendment, the bill was returned to the Senate Labor and Public Welfare Committee. The committee on October 18, 1951, again reported the bill and placed it on the calendar.

HR910—Federal Aid to Nurse Education—Public hearings have been held by the House Interstate and Foreign Commerce Committee on this bill.

S1140—To Create a Department of Health with Cabinet Status (a modification of the Hoover Commission recommendation)—several companion bills pending in the House.

S1245—To Establish an Emergency Maternity Infant Care Program—several companion bills pending in the House.

S1875—Federal Assistance to Cooperative and other Nonprofit Health Associations.

Health bills which commanded major attention in past Congresses but were not prominent in the first session of the 82nd Congress include National Compulsory Health Insurance and Federal Aid to School Health Service Programs.

National Research Council Reports on Maternal Nutrition and Child Health

A 174-page report of National Research Council, Maternal Nutrition and Child Health, insists little progress has been made in any country during the past 50 years in reducing deaths of infants under one month, "in spite of improved obstetrical skill and increased hospital deliveries." The report prepared by Drs. Kirsten Utheim Toverud and Genevieve Stearns and Icie G. Macy, also asserts that (a) birth injuries are in large part attributable to poor delivery technique or to lack of competent medical service and (b) medical schools should consider giving prophylactic pediatrics a broad place in curricula.

The report deplores a steady decline in the number of nursing mothers and states that lack of knowledge of importance of breast feeding and false information contribute to this situation. "The fact that infant mortality is declining constantly in the United States may have produced erroneous impression in the minds of many American physicians. . . . The mothers, trusting those medically trained, do not insist and both mother and infant are deprived of the physical and emotional values without trial."

Health Insurance Issue to the Front

Signs point to an early revival of open hostilities over compulsory health insurance. Governor Warren's entry into the national political arena definitely points that way as he continues to advocate a program of prepaid medical care which he states is not socialized medicine but rather social progress. The

California Medical Association, largely responsible for defeating Governor Warren's compulsory health insurance plan for that State, does not agree with him.

CIO has recently reaffirmed emphatically its support for National Health Insurance. A. F. of L. and some of the large independent unions are lined up with CIO. The Federal Security Agency has also completed drafting a bill calling for federal hospital insurance of persons over 65 years. This bill will certainly be introduced in Congress after it reassembles. It is expected that President Truman in his January "State of the Union" message again will call for compulsory health insurance.

Hospital Expansion Program

As of October 31, 1951, 747 hospital projects were under construction, aggregating 56,433 beds and including, in addition, 135 health centers. In various preconstruction stages were 144 other projects totalling 6,670 beds and 38 health centers. The Hill-Burton hospital expansion, from which the above figures were taken, is estimated to account for less than one half of all hospital expansion presently under way.

Budget Bureau Sees Only Limited Expansion of Federal Health Programs

The U. S. Budget Bureau, which has the final say on the extent of agency fund requests of Congress, believes the time has come to limit expansion of basic Federal health programs to those contributing directly to national defense. In addition, it feels a "complete and systematic review" of all Federal grants for promoting health is now in order, with a view toward economy and efficiency and elimination of possible Federal interference in State operations.

Elmer Staats, assistant director of the Bureau who outlined the government position to State and Territorial Health Officers, placed current Federal spending on all health and hospital programs, including the military and for veterans, at $1.75 billion annually. This, he added, is greater than that spent by all State and local governments. Staats listed these facts to show extent of Federal health activities: (1) more than 25 million persons, including 18.5 million veterans, 3.5 million officers and enlisted men and 2 million Federal civilian employees eligible for medical services and hospital care; (2) over 500 hospitals with 220,000-bed capacity under Federal operation or nearly 20 per cent of all hospital beds in the U. S.; (3) 10 grant programs costing $233 million concerned directly with health.

Defense Pressures Dominate Sessions of State, Territorial Health Officers

Impact of national defense on programs and budget dominated sessions of the Association of State and Territorial Health Officers, who met with the U. S. Surgeon General and officials of the Children's Bureau. Also participating were State mental health and hospital survey and construction authorities.

On opening day a Budget Bureau official made it clear that there was little prospect for new programs, or increased funds, unless the expenditures could be tied directly to the defense effort.

The conference called on Federal Civil Defense Administration to: (a) Immediately make available to States specified items for training, such as first aid units. (b) Expedite development and dissemination of instruments for and information on radiological, biological and chemical warfare defense. (c) Ease restrictions on use of matching funds. Mass immunization for tetanus was opposed because it would "use up funds and energies that could better be applied elsewhere in the defense effort." Instead, critical target States were advised to continue child immunization work and to consider the stockpiling of tetanus toxoid for limited use. (FCDA had asked the association to study the question, but contrary to some published reports had not recommended mass immunization.)

The association advised PHS to issue a clarifying statement on relationship of injections to the incidence of poliomyelitis, to try for more federal funds for the training of public health personnel, and to work with Children's Bureau to simplify and improve budgeting and reporting techniques. The association urged that State agencies be made participants in surveys under the community facilities act, that construction funds under the act be administered by State Hill-Burton agencies and that grants in general go to appropriate State agencies, rather than directly to localities.

One resolution strongly indorsed legislation for federal aid in developing local public health units. (The Senate has passed a bill on this subject, but the House bill still is in committee.) Another resolution, approved after once being defeated, states that the

association ". . . offers its cooperation" to AMA, American Hospital Association and American College of Surgeons, and recommends that every State agency concerned with hospital licensure or construction "cooperate to the fullest extent with representatives of these associations in their efforts to develop mutually acceptable (hospital) standards."

3 More Late Bills Filed

Senator Hubert H. Humphrey (D, Minnesota) introduced S2325, establishing a Bureau of Accident Prevention in Department of Labor (he sponsored a similar measure two years ago). Senator James E. Murray (D, Montana) put in a smog abatement bill (SJ Res. 110), directing Public Health Service and Interior Department to intensify efforts toward prevention and control of air pollution. And over on the House side of Capitol, fiery Rep. Clare Hoffman (R, Michigan) proposed (H.Res.472) establishment of a 5 member special committee to investigate "alleged abuses in the hospitalization, medical and surgical care of veterans." With particular emphasis, he added, on conditions in State of Michigan. Note: Senator Humphrey has decided to wait until 1952 to introduce his bill, already drafted, to overhaul medical department of Veterans Administration.

Dr. Arthur Chase Honored

On November 18, 1951 between 400 and 500 citizens of Plainfield celebrated Dr. Arthur Chase's 50th year in the practice of medicine by holding an "open house testimonial." Again on November 27 Dr. Chase was honored, this time by the Plainfield Rotary Club.

Dr. Chase, in addition to his faithful medical service, has served the community as a member of many civic organizations. He has been health officer for the town of Plainfield since 1902 and has also served for a number of years as the health officer for the towns of Brooklyn, Killingly and the borough of Danielson. He has been the chairman of the board of finance of the town since October 1935. He has been medical examiner for the towns of Plainfield, Canterbury and Sterling since 1929. He has been a member of the board of education for eight years and a member of the fire district committee since its inception in 1937.

The guest speaker at the "open house" was Dr. Angelo J. Gulino. Mr. John A. Leahy, one of Dr. Chase's oldest friends presented to Dr. Chase, on behalf of the people, a handsome 8 x 10 gold plaque, with the inscription, "To Dr. Arthur A. Chase, from the residents of Plainfield, in appreciation for 50 years of medical service, 1901-1951." He was also given a check for a sum of money.

Preliminary Results of Cancer Bulletin Survey Announced

On December 1, 1951 Dr. Stanley H. Osborn, commissioner of health, announced that 26 per cent of the replies to a questionnaire concerning the *Cancer Bulletin* had been received by the State Department of Health. For the past two years this *Bulletin* has been sent to all physicians in Connecticut as a part of the Cancer Control Program.

Questionnaire cards were mailed October 19, 1951 to 3,095 Connecticut physicians by Dr. Matthew H. Griswold, chief, Division of Cancer and Other Chronic Diseases. Tabulation of the 804 replies received by the Division of Cancer and Other Chronic Diseases has indicated that 89 per cent of the physicians replying were favorably impressed by the publication. Six per cent did not care for it and nearly 4 per cent were noncommittal. Two per cent of the replies received to date indicate that the *Bulletin* is not being received.

The reply cards received are being matched with the physicians' directory in order that a revision of the mailing list can be accomplished. While the response in the replies so far returned is overwhelmingly *favorable* to the Bulletin, it cannot be accepted as an endorsement of the publication by all the members of the medical profession in Connecticut since replies have been received from only one-quarter of that group. In order that a true expression of the majority of physicians may be obtained, all doctors are urgently requested to return their reply cards with their own comments as soon as possible.

Tuberculosis Association Elects Officers

Dr. Cole B. Gibson, Meriden, was re-elected vice-president of the Connecticut Tuberculosis Association at the organization's twelfth annual meeting, October 10, in Hartford. Dr. W. Haviland Morriss, Wallingford, was elected assistant treasurer and Dr. Charles C. Wilson, New Haven, member of the executive committee.

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington, *Chairman*
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
John E. Flaherty, Rockville
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Medical Education Campaign Under Way

The first mailing to Connecticut physicians concerning contributions to the American Medical Education Foundation was completed in December.

Dr. Brae Rafferty, president of the Society, is chairman of the State-wide committee to raise funds for the Foundation and its members comprise the presidents and secretaries of County Medical Associations. Direction of campaign activities is in charge of the Society's Committee on Public Relations, headed by Dr. William G. H. Dobbs, Torrington.

The American Medical Education Foundation is a non profit corporation organized to raise funds among physicians to help meet the financial problems that confront medical schools. Its activities are being implemented by the National Fund for Medical Education, headed by former President Herbert Hoover, and which plans a campaign to raise additional funds from non medical sources.

Most State Medical Societies are conducting campaigns for the Foundation. The Medical Society of Pennsylvania and the Medical Society of the State of New York have announced quotas of one million dollars each and the California Medical Association has already contributed $100,000.

Fifty-Four Per Cent of AMA Income Devoted to Scientific Activities

The American Medical Association spent more than four million dollars, or 54 per cent of income, to finance its varied scientific activities during 1951. This is graphically presented in the Association's new *Guide to Services*, recently published to replace its annual *Handbook*. The financial report also indicates that expenditures for public information and services accounted for 23 per cent of income; socio-economic activities, five per cent; administration, including employees' annuities and retirement, seven per cent; legal and legislative functions, three per cent; and State medical journals (returned to State medical journals), eight per cent.

The 116-page booklet contains a wealth of information concerning the many services of the Association's councils, bureaus and departments. It contains a considerable amount of information published for the first time in a booklet of this type. Attractively covered, the publication is 6 by 9 inches in size and contains several indexes for ready reference. A limited number of copies are available at the offices of the State Medical Society.

Conference On TV in Health Education

The first Connecticut conference on the use of television in health education was held in New Haven November 20. Approximately 30 leaders of local medical and dental societies and voluntary and public health agencies attended the meeting, sponsored by the management of Radio Station WAVZ.

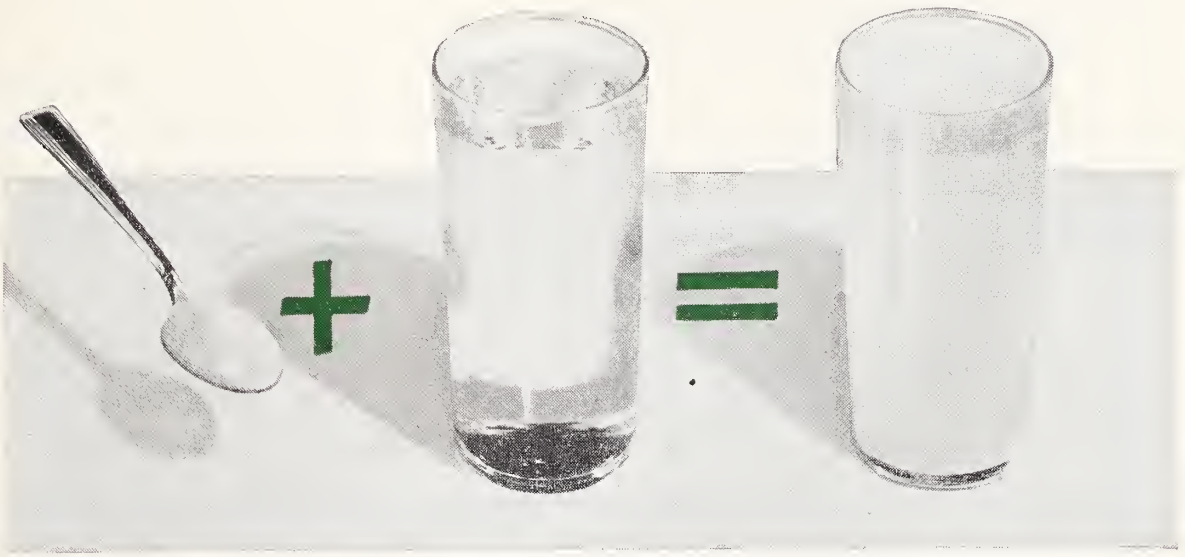
The conference was held to discuss the applications of television in the educational programs of local organizations. One of the main discussion points centered about the need for top-level planning to assure solution of the many technical problems encountered in television production. These are estimated to be five times more involved than the problems of radio production. A second conference is to be planned following further study by interested agencies.

New Office Plaque

An attractive plaque for display in physicians' offices was recently announced by the American Medical Association. Bearing the AMA seal, the plaque measures 8 by 12 inches and is designed for wall or desk display. It presents the following message: "TO ALL MY PATIENTS: I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical care is based on a friendly, mutual understanding between doctor

Normohydration

FOR BOWEL REGULATION



Typically, the constipated stool is dehydrated, whereas the diarrheal stool or that induced by salines and irritants is hyperhydrated, containing free water.

When Metamucil is employed for the management of constipation, it is mixed in a full glass of cool liquid. The ingested liquid containing the mucilloid promotes normohydration.

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

and patient." The plaque is available through the Order Department, American Medical Association, at a cost of one dollar.

New England Health Institute Meets in Connecticut Next June

The 18th New England Health Institute will be held June 18-20 at the University of Connecticut, Storrs, according to an announcement by Dr. Stanley H. Osborn, Connecticut State Health Commissioner, and Dr. Albert N. Jorgensen, president of the University.

Sponsored by more than 30 New England public health agencies, medical and dental associations, universities, and health organizations, the Institute was organized in 1922 to advance health improvement.

Mr. Chester S. Bowers, Hartford, chairman of the Institute's Executive Committee, has appointed members of the Connecticut State Department of Health, the University of Connecticut and local and state health organizations to a number of special committees to plan the three-day event. Speakers and discussion leaders will represent every section of Northeastern United States and it is anticipated the program will present one of the outstanding health conferences of 1952.

Connecticut has been host to the Institute on three previous occasions—1922, 1929, and 1940. All of these conferences were held in Hartford. The June meeting will mark the first time for the Institute to convene at the University of Connecticut, an arrangement made possible by a term-end vacation for students at that time.

The first New England Health Institute was held in Hartford in 1922 and has rotated through all of the New England States since that time. Although originally proposed as an annual event, this did not always materialize. On ten occasions the Institute was not held because of war or unfavorable economic conditions.

THE DOCTOR'S OFFICE

Clair Rankin, M.D. announces the opening of an office for the practice of internal medicine and hematology at 137 Jefferson Street, Hartford.

William A. Ryan, M.D. announces the opening of an office for the general practice of medicine at 65 South Street, Stamford.

John Shoukimas, M.D. announces the opening of an office for the practice of general surgery at 44 Garden Street, Hartford.

Sidney Vernon, M.D. announces the opening of an office for the practice of general surgery at 889 Main Street, Manchester.

New England Council of State Medical Societies Sponsors Boston Conference

One of the most successful conferences to be sponsored by the New England Council of State Medical Societies was held at the Copley-Plaza Hotel, Boston, November 18.

Dr. Louis H. Bauer, president-elect of the American Medical Association, guest speaker at a dinner following the afternoon conference, spoke on the topic "Medical Care Insurance and the Progress of Medicine."

The conference program, "Professional Relations in Medical Care Insurance," attracted an audience of more than 100 physicians, hospital administrators, executives of insurance companies and Blue Cross and Blue Shield plans, and representatives of health organizations.

Topics included professional relations with hospital and surgical plans, the structure of fee tables and attitudes of physicians and subscribers concerning health insurance.

Dr. Joseph H. Howard, Bridgeport, president of the Council, was presiding officer and speakers included Dr. Charles G. Hayden, executive director of Massachusetts Blue Shield; Frank E. Smith, director, National Association of Blue Shield Plans; John H. Miller, vice-president, Monarch Life Insurance Company, Springfield; Dr. William H. Horton, managing director, Connecticut Medical Service; Dr. Thomas J. Danaher, Torrington; Dr. Charles L. Farrell, Pawtucket, Rhode Island; Dr. Joseph A. Holmes, Waltham, Massachusetts; and Dr. Daniel G. Sullivan, Nashua, New Hampshire.

PATRONIZE OUR ADVERTISERS

TODAY'S HEALTH

Published by the American Medical Association, *Today's Health* brings authentic health information to the home, school and public library.

More than two million people now find this health magazine in their physicians' offices and the number is increasing daily.

Today's Health is a modern, progressive medium of sound health information and should be available in *every* physician's office. Subscriptions are sponsored by the Woman's Auxiliary to the State Medical Society.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please enter my subscription to *Today's Health* at the special physicians' rate of $3.25 for three years—or $1.50 for one year.

Check enclosed herewith ☐

Send bill with first issue ☐

Signed: .....

Address .....

.....

FROM OUR EXCHANGES

In "Surgical Management of Conditions and Diseases Affecting the Liver" *(Jour. Internat. Coll. Surg.,* XV 3) Herbert Acuff of Knoxville, Tennessee discusses in detail diseases and injuries of the liver, including abscesses, cysts and neoplasms of various types, various kinds of trauma and cirrhosis, with special emphasis on the latter. Three cases of trauma are reported to illustrate the ability of the liver to tolerate major surgical procedures. Emphasis is placed on the fact that cirrhosis is no longer considered a purely medical problem. The importance is indicated of blood chemical studies and liver function tests.

* * * *

"Induction of Labor" by Fairlee *(The Practitioner,* 166.992) discusses the indications and methods of procedure used by the author when inducing labor. Several other articles listed under "Midwifery in General Practice" may be found in this same issue.

* * * *

The New York State Journal of Medicine (51.7) contains a panel discussion on "Present Status of the Sulfonamides and Antibiotics in Pediatric Practice" by Neter, Roegseggar, Fisher, Soule and Karelitz. One is impressed by the rapidity with which knowledge of this subject has accumulated in the past 15 years since the administration of the first sulfonamide in the mid 30's. Today progress in the broad field of chemotherapy has been so rapid it is difficult to postulate principles because the knowledge of the mode of action is so limited. Without eternal vigilance it is readily understandable how one may fail properly to use a newer and perhaps superior member of the antibiotic family.

* * * *

In "Reversibility of Early Bronchiectasis" *(N. Y. State Journal Medicine,* 51.9) Finke of the Genesee Hospital Chest Clinic at Rochester, N. Y. discusses the implications for prevention and therapy of bronchiectasis. His claim for reversibility of bronchiectasis is based on the fact that in the early stage there is growing evidence to show that the disease is not necessarily associated with permanent lesions. Lung surgery should be postponed, therefore, in patients whose lesions may be transient. Vigorous antibiotic treatment and other conservative measures may achieve elimination of the underlying bronchopulmonary infection and of any other factors producing bronchial dilatation. The treatment is considered essential even if surgical intervention ultimately should be found necessary.

* * * *

Should local water supplies be fluoridized for the prevention of dental caries? Boucher covers this subject well in *California Medicine* (74.8). He believes caries prevention is even more important than caries control and is both a medical and dental problem. The presence of fluorides like the lack of vitamin B complex inhibits the enzyme systems of acidogenic bacteria. One theory regards this inhibition as accounting for the reduction of dental caries. Fluorides are used easiest and most economically in commercial water supplies, 1 part sodium fluoride to 1,000,000 parts of water. In the fetus or in a baby or child forming teeth, experiments have shown that fluoride becomes incorporated in the enamel of the teeth, rendering them less susceptible to caries. After eight months when the permanent teeth have become formed, fluorides are believed to be without effect. Local applications of sodium fluoride can reduce the incidence of dental caries if scientifically applied in recently erupted teeth with intact enamel, provided these have been preceded by a thorough dental prophylaxis. Tablets, lozenges, dentifrices and mouth washes have little effect since they are in the form of insoluble calcium fluoride to comply with Pure Food and Drug Act which excludes topical preparations. In milk, fluoride forms insoluble calcium fluoride, again of no use. The importance of prevention through dental health education and proper home care is emphasized. The question of proper dentifrices and special local treatment of children's teeth should remain a problem for each individual's dentist as diet and general health are problems of the family doctor. Fluoride in proper amounts and under control to maintain a percentage content in water supplies is beneficial for the prevention of caries up to about the eighth year. Too high concentration will produce nothing and even pitting of the enamel of teeth in many children.

* * * *

CLASSIFIED ADVERTISING

$4.00 for 50 words

5¢ each additional

25¢ extra if keyed through JOURNAL

Payable in advance

Wanted Experienced Laboratory Technician, registered, for modern 200 bed hospital. Write Box No. 550, Bristol, Connecticut. Salary $300.

Approved interneships (rotating), and residencies in medicine and obstetrics-gynecology; and surgical residency approved only for training in preparation of surgical specialties; for July 1, 1952 or earlier; typical general hospital, modern, well-equipped; wide diversification of diseases; average patient census around 185; plenty of work; good recreational facilities, especially marine. Full-time radiologist, pathologist and anesthesiologist. Stipend for internes $1,200 per year and for residents $1,500-$1,800 per year, plus uniforms and maintenance. Class A medical school graduates only. The Lawrence and Memorial Associated Hospitals, New London, Conn.

PATRONIZE JOURNAL
ADVERTISERS

ORTHOPAEDIC APPLIANCES
BUILT TO
PHYSICIANS' PRESCRIPTIONS
ONLY

SHIRLEY BROS.
26 ASHLEY STREET, HARTFORD
Phone 6-3748

Braces - Belts - Etc.
ESTABLISHED 1910

THE
REGAN CLINICAL LABORATORY
27 ELM STREET, NEW HAVEN, CONN.

Serving the physicians of New Haven since 1923

6 Technicians — 24 hour service

Technician automobiles equipped with radio phones to facilitate prompt dispatching

CROTON MANOR SANITARIUM
ALBANY POST ROAD, ROUTE 9
CROTON-ON-HUDSON, N. Y.
Tel. Croton 1-4731

A private sanitarium for individual care and treatment of nervous and mental disorders; senile and habit cases. Beautifully furnished. Overlooking Hudson River. Every room with bath. All accepted therapies administered. Brochure on request. Licensed by New York State Department of Mental Hygiene and approved by the American Medical Association.

Filomena Doherty, R.N., *Director*
George L. Lake, M.D., D.P.N., *Physician-in-Charge*
35 miles from New York City

MILFORD LABORATORY
69 BROAD STREET, MILFORD, CONN.
Tel. 2-1153

To serve the Physicians for the analysis of blood, urine, etc.
E.K.G. and Basal Metabolism readings

GEORGE S. ZUCCALA, *Medical Technologist*
F.A.C. M.T. *Director*
24 hours service

Keep medicine in the hands of M.D.s.

Pepperidge Farm
WHOLE WHEAT
Bread



Made from undegerminated flour containing all the natural vitamin elements of wheat, including the wheat germ in its natural form. The flour is stone-ground fresh daily in an old New England grist mill. Each loaf is hand-kneaded, and only 93-score creamery butter, fresh whole milk, unsulphured molasses, honey, cane-syrup, salt, water, and yeast are used.

Our White Bread is made with unbleached white flour.

For information about our special SALT-FREE Bread, please write to:

MARGARET RUDKIN, Director
PEPPERIDGE FARM NORWALK, CONNECTICUT

"The Management of Gastro Intestinal Hemorrhage by James O. Burke *(West Virginia Med. Jour.,* 47.2) covers the generally accepted measures of bed rest and sedation. The management of these hemorrhages is directed at stopping the hemorrhage and correcting the effects of blood loss while at the same time attempting to determine the site of the bleeding. Variations of opinion as to diet, transfusions and surgery are covered.

* * * *

Leinfelder's article, "The Diagnostic Significance of Some Ocular Complaints" *(South Dakota Jour. Med. & Pharm.,* Feb. 1951) points out the fact that every complaint referable to the eyes is neither indicative of ocular disease nor of a need for glasses. Nor is every patient who complains of twitching of the lids, irritation of the conjunctiva, or fatigue from reading in need of eye treatment. Most frequently such complaints are the result of fatigue brought on by the complications resulting from the rapid rate of speed and high pressure under which we live today. The ophthalmologist is no better able to solve the problem of headaches than any other practitioner of medicine. Ocular causes of headaches are few. Very infrequently are they an indication for glasses and on the rarest of occasions do they indicate primary ocular disease.

* * * *

"Rabies in Indiana: A Human Case" is preesnted in the *Journal of the Indiana State Medical Association* (44.2) by J. W. Jackson. The author states that rabies is said to have been prevalent in Asia in ancient times. Gradually it spread westward, assuming epizootic proportions in Europe early in the 18th century. Its first recorded appearance in the United States was in Virginia in 1753. It reached California many years later in 1889. Statistics from the Bureau of Animal Industry of the U. S. Department of Agriculture appears to indicate that the incidence of the disease in the United States is increasing. The author suggests not alone an effective program for statewide control but, better still, a nationwide one. Although rabies may not be an important cause of death in man, it has been the cause of either the death or the destruction of many valuable domestic animals.

* * * *

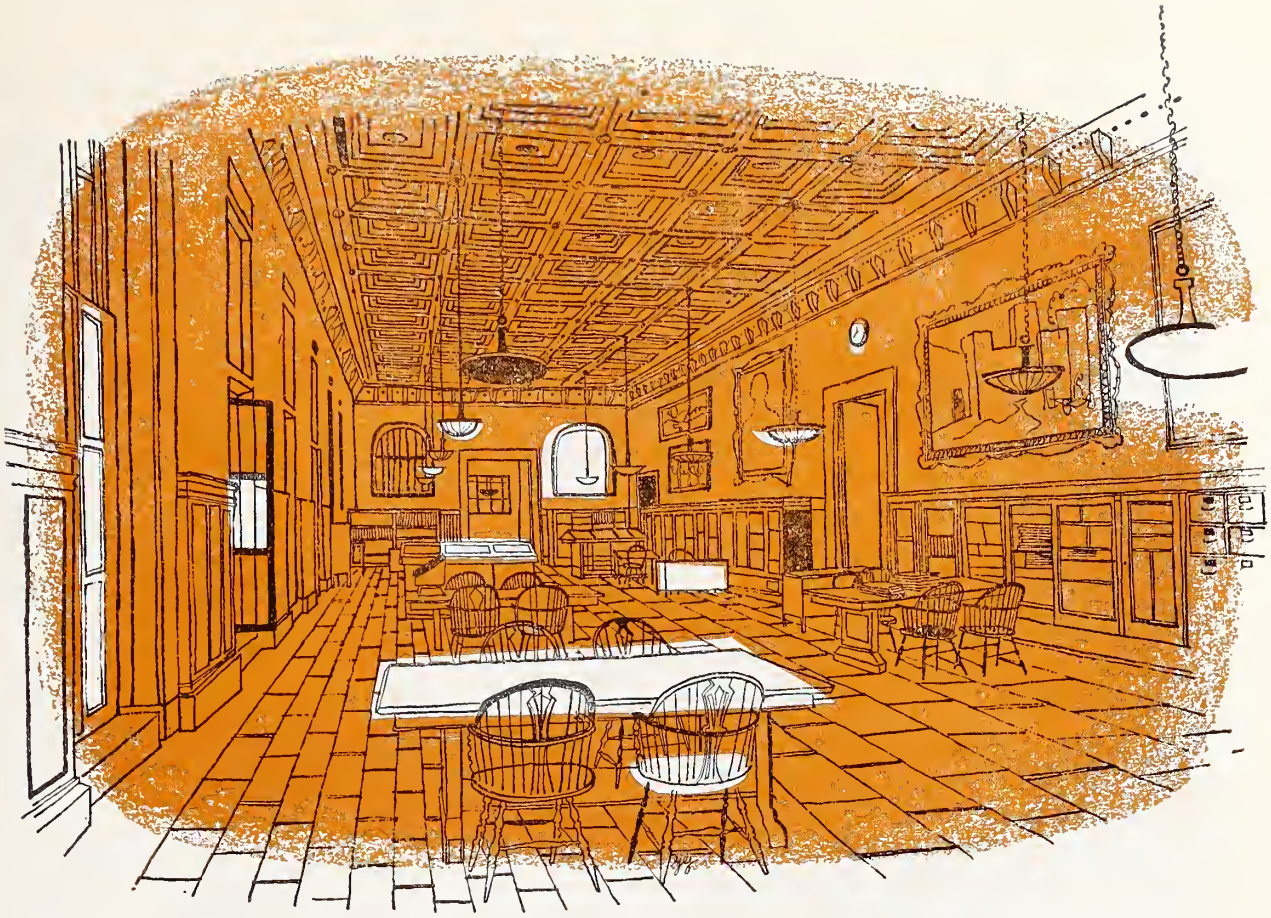
In "The Significance of Ascites" *(West Virginia Med. Jour.,* 47.3) Nelson states that the demonstration of free fluid in the abdomen should make one think at once of three basic conditions: (1) disease elsewhere in the body resulting in abnormal circulation in the peritoneum; (2) disease of the peritoneum itself, either primary or secondary; (3) unusual and obscure conditions, notably Meigs' syndrome, where there is no acceptable explanation for the fluid formation. A remarkable case report is included.

* * * *

"The Problem of the Medical Laboratory Technologist" is outlined in three articles published in *New England Journal of Medicine* (244.4) entitled "Educational Requirements of the Medical Technologists" by Philip M. Richardson, "Training of the Medical Technologist" by Elinor Judd, and "Problems in the Maintenance of Adequate Laboratory Staffs" by Nickerson. The serious shortage of properly qualified medical technologists has become a matter of such grave concern that a group of laboratory directors, technologists and educators induced the Massachusetts Central Health Council to appoint a study committee under the chairmanship of the assistant director, Division of Communicable Diseases, Massachusetts Department of Public Health. This committee is seeking means of alleviating the shortage of laboratory technologists. The changing pattern of medical care in recent years has resulted in a tremendous expansion of the activities of the clinical laboratory and in an increasing shortage of well selected candidates for training as medical technologists. This shortage is nationwide and restricts the work of many hospitals, clinics and schools.

* * * *

In "Addison's Disease Occurring in Two Brothers" *(British Med. Jour.,* 4698) Briggs, Goodwin and Wilson present the results of a careful investigation of the influence of heredity on and a review of the literature to determine the possibility of a familial factor in Addison's Disease. In the two reported cases the cause of the disease was attributed to primary suprarenal atrophy. In view of the suggestive but inconclusive evidence afforded by this and other cases reported, the authors consider that the familial and genetic aspects of Addison's Disease merit further study.



From among all antibiotics, Internists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin readily passes into the blood stream, whence it diffuses rapidly into all the tissues and fluids of the body.

Aureomycin is a broad spectrum antibiotic that has been shown to be effective in a wide variety of infections of bacterial, rickettsial and large viral origin.

Aureomycin has been reported to be effective in

Acute Amebiasis	Hepatic and Biliary Tract Infections*	Respiratory Infections*
Anthrax	Influenza	Rickettsialpox
Acute Brucellosis	Leptospirosis	Septicemia*
Chancroid	Lymphogranuloma Inguinale	Rocky Mountain Spotted Fever
Shigella Dysentery	Pericarditis*	Boutonneuse Fever
Endocarditis*	Psittacosis	Tick-Bite Fever
Erysipelas	Q Fever	Typhus
Granuloma Inguinale	Rat-Bite Fever	Tick Typhus
	Relapsing Fever	Tularemia

*When caused by Aureomycin susceptible organisms.

Throughout the world as in the United States, aureomycin is recognized as a broad spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President Mrs. F. Erwin Tracy, Middletown
President-Elect, Mrs. Barnett Freedman, New Haven
First Vice-President, Mrs. Ralph Ogden, West Hartford
Second Vice-President, Mrs. Dewey Katz, Hartford
Recording Secretary, Mrs. Arthur H. Jackson, Washington
Corresponding Secretary, Mrs. Harry C. Knight, Middletown
Treasurer, Mrs. William V. Wener, Norwich

State News

NATIONAL AUXILIARY CONFERENCE

The Eighth Annual Conference of State Presidents, Presidents-elect and National Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held in Chicago on November 14 and 15, 1951. The first Conference was attended by 40 Auxiliary members, this year's by 103 Auxiliary members. All 48 States, Hawaii, Alaska and the District of Columbia have organized Woman's Auxiliaries; all but three of these were represented at this meeting.

"Working Together for Health" was the Conference theme. This meeting offers each State a direct participation in national ideas. New viewpoints from constituent States are welcomed, therefore a system of panel discussions was organized with State representatives as moderators and participants. In the last analysis, the national may direct but it is the local planning and the acts taken to meet local health needs that make the Woman's Auxiliary effective.

Mrs. Harold Wahlquist, national president, announced that national programs had been sent to every State chairman so that each member could be reached. The Woman's Auxiliary now numbers 57,000 members and has representation on the National Nursing Career Board and the Advisory Committee of the National Public Health Units.

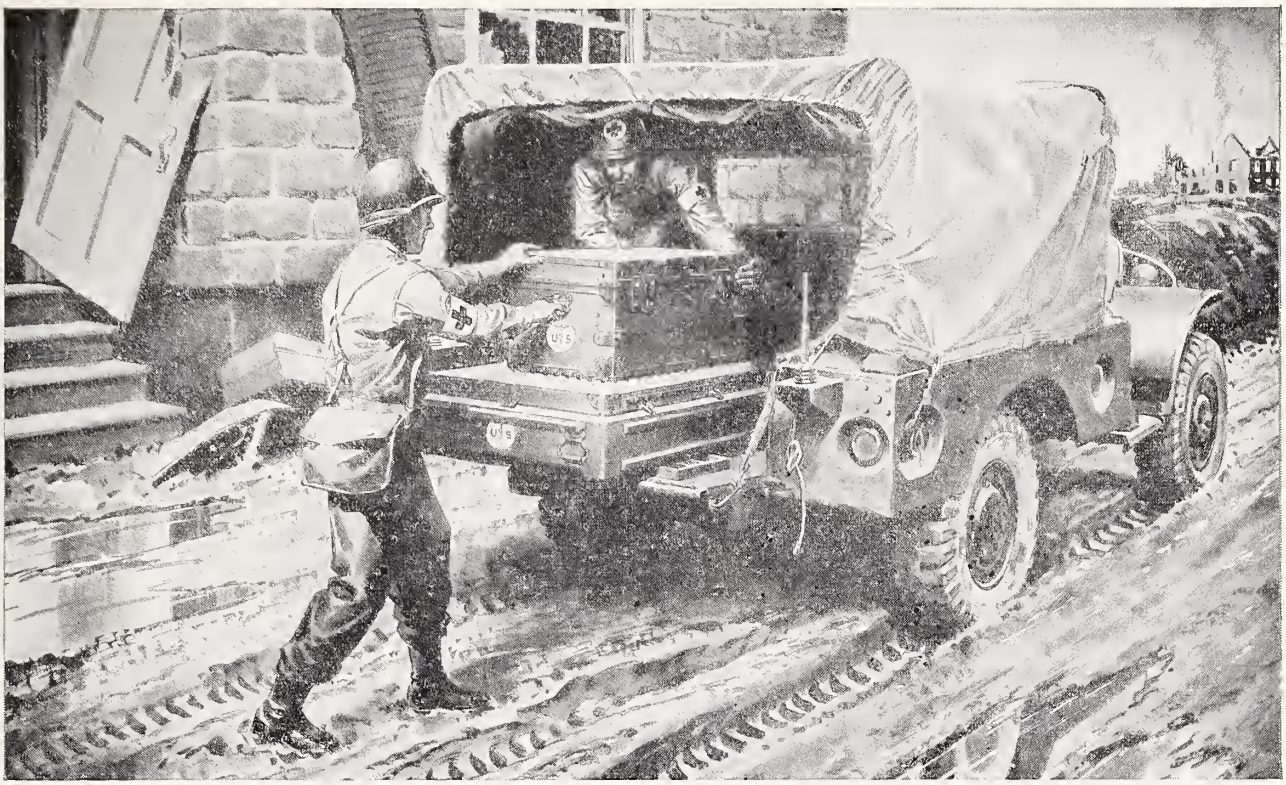
Mrs. Ralph Eusden, president-elect, was introduced as presiding officer of the Conference. Mrs. F. Erwin Tracy was elected Conference secretary. It was a signal honor for Connecticut and one that Mrs. Tracy discharged with efficiency and dispatch although it meant much work and late hours.

Dr. Ernest Howard, assistant secretary of the AMA, spoke on "The AMA and the Woman's Auxiliary, 1951-1952." He said that the 1952 election should be high on next year's agenda of activities. We must be informed, aware, alert. We must vote and urge our families to exercise this democratic right. He lectured and showed slides on procedures and compilations of various boards of the AMA and the allocation of funds to operate these departments. He discussed expenditures for Scientific Activities, Public Information, Socio-Economics and Legislative Analyses, State Journal Advertising and Association Maintenances. During the past year, writers of sixteen different magazine articles on medical advice and techniques have come to the AMA offices for assistance and information. This is public relations of the finest kind. A handbook is now being prepared which will publicize the activities of the AMA and will be sent to every physician. Another pamphlet for informing the public of what the AMA is and does also is being prepared. Our responsibility is to tell the nation what the AMA Councils are doing. For example, the Council on Rural Health has done such a splendid job that the relationship between the doctors and the rural population of this country is one of utmost respect and helpfulness.

This lecture was followed by a panel in Organization and Membership with Mrs. Leo J. Schaefer as moderator. Eligibility to membership in the Woman's Auxiliary is a privilege that is extended to women through their husbands' membership in the AMA. Personal salesmanship at the local level is vitally important and every physician's wife should be contacted. "Be a Member—Get a Member" is the slogan for 1952, with 10,000 new members the goal.

The Finance Panel gave the rudiments of dues collecting, with stress on uniformity and continuity. Dues must be paid promptly so that county, State and national deadlines may be met.

The luncheon guest speaker this first day was Mr. Edwin O'Connor, managing director, Insurance Economics Society of America. Mr. O'Connor urged alertness to changes in our form of government. "The danger of our day is that between the things that are too big for us to do and the little things that we won't do, are the vast number of



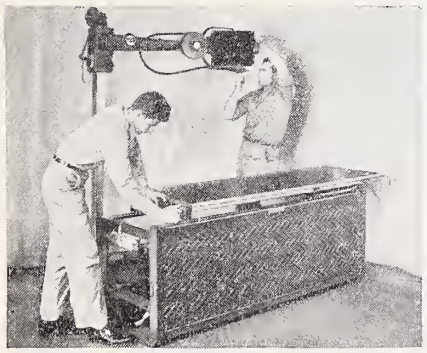
ARMED SERVICES ACCEPT PORTABLE FIELD X-RAY

New Picker Unit Operates Anywhere: Assembles in 5 Minutes

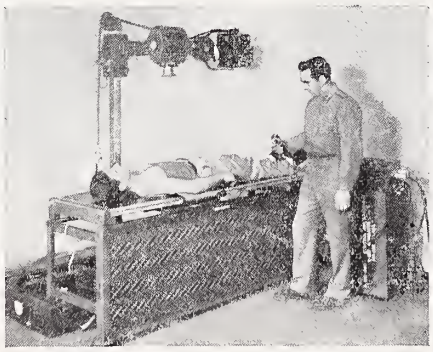
After months of rigorous proving tests, medical departments of all Armed Services have jointly accepted a new x-ray unit for operation in the field. Civil Defense authorities also see in its complete self-sufficiency an answer to the problem of providing x-ray facilities in disaster areas.

Like its forerunner, the U. S. Army Field X-Ray Unit of World War II, the new machine was designed and developed by the Picker X-Ray Corporation on its own initiative and at its own expense, with no development cost to the government. Quantity production is already well under way.

The unit is so portable and so self-sufficient that it can be used anywhere, even in forward areas. For transport it knocks down into two chests which are light enough to be moved by a medical team, compact enough to be carried in a jeep, or light truck, and rugged enough to be safely parachute-dropped. On arrival, the machine takes only five minutes to assemble for use in Mobile Field and Evacuation Hospitals. It will operate anywhere: on community power lines if available, or using a companion portable gasoline motor-generator. Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



FIVE MINUTES is all it takes to assemble the new Picker machine; no tools are needed. The lid of the long chest becomes the table front: other parts unfold into position or are attached in sequence. Packing members become operating parts.



HORIZONTAL RADIOGRAPHY and fluoroscopy are equally easy. The unit will operate continuously for fluoroscopy at 5 MA. and will withstand storage conditions from 50° below zero to 120° F. at humidity up to saturation.

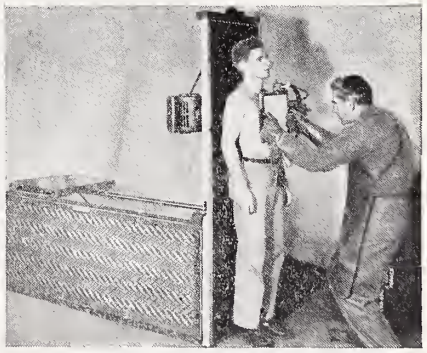


TABLE TOP SWINGS to vertical for fluoroscopy or radiography of upright patient. Sealed fluoroscopic screen is proof against warping or fungus invasion. Lead-rubber apron and gloves can be packed right into the same chest with the tubehead.

important things we don't do. We are, therefore, engulfed by complacency and apathy as we travel the road of the welfare state, more and larger handouts from State and national governments. Call it what you will, it is socialism."

Nurse Recruitment Panel urged cooperation with Nurse Recruitment organizations in each State, as part of both an emergency and long range program. "Future Nurse Clubs" should be organized in our junior high schools or in freshman and sophomore years at senior high schools.

The panel on *Today's Health* placed the responsibility of increased circulation on our shoulders. We should try to promote the Group Study Plan in our schools. A subscription of ten or more copies procures a free one for the teacher's use. Some Auxiliary members have placed copies upon druggists' counters for sale.

Mrs. Rollo K. Packard, chairman of the Reference Committee, offered her committee's services to any State President. It acts in an advisory capacity on organizational problems beyond the scope of State or national chairmen. Mrs. Luther Kice, a national past president, urged that State presidents avail themselves of this service.

Mrs. Arthur Herold, immediate national past president, was moderator of the Community Service Panel. She urged development of an interested, participating membership, rather than just a dues paying one. As doctors' wives, members should promote the cause of community health, establishing a reputation for dependability and willingness to serve. They should promote a good working relationship with other organizations interested in community health.

The second day of the Conference began with a panel on "Health Days." Mrs. Tracy reported on the "Health Day" sponsored by our State. Minnesota, Nevada, Indiana, Arkansas and Wisconsin reported on their programs. Exhibits, medical films, formation of health councils, programs on food sanitation, mental health and accident prevention were all covered. "Health Days" can be of great interest and value but require much planning, organization and cooperation of health groups.

It was announced that the *Handbook of the Woman's Auxiliary* was in the process of revision. Questionnaires were distributed and we were asked to contribute pertinent suggestions.

The Civil Defense Panel cited Connecticut as one of the five main target areas of our country. Members should be trained as speakers on civilian defense, should take or teach home nursing courses, donate to and help with blood donor plans. The Auxiliary *Bulletin* should provide members with a list of emergency equipment. The Massachusetts delegate announced that her State Auxiliary had combined with forty-nine other organizations to work on the Civil Defense Program. New Hampshire has formed surgical and medical teams. Mrs. O. W. Robinson of Texas felt that to make civil defense alive every person in the community must be reached. Mrs. Herman Farber of Virginia felt that civil defense could be one of our best public relations media if whole heartedly supported.

At luncheon the Honorable Walter Judd, M.D. a member of Congress, spoke. He urged us to participate in politics.

The afternoon session included a review of Clarence Manion's book, *Key to Peace*. A synopsis and analysis of various legislative bills such as the School Health bill, Federal Aid to Medical Education, Maternity and Infant Care for Families of Men in Service, were given and discussed. Mrs. Eusden summarized the Conference's work, the report of the Conference Recommendations Committee was made, and the meeting was adjourned.

This conference is definitely a *must* for every president-elect.

Lillian L. Freedman,
President-elect

MEMBERSHIP DRIVE

"Be a member, get a member' is our National slogan for this year. The national goal of the Woman's Auxiliary to the American Medical Association is 10,000 new members. Our Connnecticut Auxiliary now has over 1,100 members. There has been a steady increase in membership since organization and we have a very good rating in National membership reports. Now we need the support and assistance of each one of our present members to maintain and increase this excellent record. Every member can assist by (1) making personal contacts and (2) by explaining our Auxiliary program to eligible members.

A few pertinent facts regarding membership may prove valuable to every member as well as to the County Membership Committees. First, dues for the fiscal year should be paid as early as possible to assist the County Treasurers and Membership chair-

Cool and Mild!



CAMEL

men in making their State and National reports. Second, dues must be paid before December 31. After that date a member is no longer in good standing and the name is removed from the State Auxiliary file until reinstatement since the State Auxiliary must pay National Auxiliary dues for every member reported. Third, all changes in address must be reported promptly by the individual members to the County Membership chairman in order to keep the mailing list accurate. Fourth, new members who join after March 1 cannot be listed in the August JOURNAL of the current year, due to the schedule for reports. According to the present system established by the State Auxiliary Board (1948-49) the vice-president prepares the membership list for the August JOURNAL before retiring from office in May. In order to obtain this list of members in good standing, each County chairman carefully checks the county file to correct names, addresses, and dues paid in the county and sends the up-to-date list to the State Membership chairman by the end of March. The State Membership chairman checks the State Auxiliary file with each county report for corrected names, addresses and dues paid before the annual State meeting at the end of April or first of May.

After the annual meeting the State Auxiliary membership files are sent to Remsen Advertising Company in New Haven where our mailing list is checked and corrected and the names of members are printed alphabetically according to counties, towns and names in each town. This printed list of members is then sent to the STATE MEDICAL JOURNAL office in June, as requested, for the August JOURNAL.

The accuracy of State and National reports depends on prompt and accurate reports from each county. It is the responsibility of each member to assist her County Membership chairman by reporting to her promptly any change of address, loss of members, or prospective members.

The County Membership chairmen are endeavoring (1) to keep an accurate up-to-date membership file, (2) to send their final corrected annual report of members in good standing by the end of March, and (3) to keep on file all State and National instructions for future reference.

Personal salesmanship on the local level is the key to success. Please help us keep an accurate up-to-date mailing list as our membership is increasing. Each county chairman should contact the county medical secretary for the names of new medical members whose wives are eligible and start her campaigns early in the year. If membership campaigns are conducted after the first of April, new members should be informed that their names will not appear in the August JOURNAL of the current year, as the County Membership reports will already have been forwarded to the State Membership chairman.

Mary Ann Ogden,
First Vice-President

TODAY'S HEALTH SUBSCRIPTION CONTEST

You will find a convenient order blank for *Today's Health* on the Public Relations page in this issue. Your county Auxiliary will receive the proper credit for the order. This AMA subscription contest closes on January 31.

The fifty per cent discount to the medical profession applies to gift orders as well as to their own personal subscriptions, making the prices as follows: $1.50 for 1 year, instead of $3; $2.50 for 2 years, instead of $5; $3.25 for 3 years, instead of $6.50.

Dolly Buckley,
Today's Health Chairman

County News

HARTFORD

A legislative meeting was recently held at the home of Mrs. Stevens J. Martin, president. Dr. William H. Horton addressed the group. Tea was served by Mrs. D. J. McCrann and her committee.

The dance held on December 1 at the Farmington Country Club was a social and financial success. Mrs. Ralph Tovell, dance chairman, announced that over $200 will go to the Welfare Fund.

Mrs. N. E. St. John, welfare chairman, reports a contribution made towards the purchase of a television set for the State Hospital in Norwich.

MIDDLESEX

On the afternoon of November 14, fourteen members were conducted on a tour of the Connecticut State Hospital in Middletown. The tour was followed by a discussion of therapeutic treatments used at the hospital.

AUXILIARY MEMBERS
PATRONIZE OUR
ADVERTISERS

Cortone®

Safety in the Prolonged Control of RHEUMATOID ARTHRITIS



Successful clinical experience with CORTONE in many *large series* of patients reveals the safety of this product in individualized dosage. One investigator notes: "We have not been impressed by the severity or frequency of side-effects . . . The side-effects due to excessive adrenal cortical hormone disappeared when the hormonal agent was discontinued."

Norcross, B. M., *N. Y. State J. Med.* **51**: 2356, Oct. 15, 1951.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.*

Cortone®
ACETATE
(CORTISONE Acetate Merck)

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

SPECIAL NOTICES

HARTFORD HOSPITAL MEDICAL EDUCATION PROGRAM

Saturday Mornings, 11 o'clock
Hartford Hospital Amphitheater
80 Seymour Street, Hartford, Connecticut

December 29, 1951

Joseph N. D'Esopo, associate clinical professor of medicine, Yale University School of Medicine

Basilar Tuberculosis

January 5, 1952

Joseph Benotti, chief of the clinical chemistry laboratory, New England Center Hospital

The Laboratory—Facts and Foibles

January 12, 1952

Franklin L. Payne, M.D., professor of obstetrics and gynecology, University of Pennsylvania

The Gynecological Care of the Post-menopausal patient

January 19, 1952

Philip D. Wilson, M.D., clinical professor of orthopedic surgery, Columbia College of Physicians and Surgeons

Orthopedics—Past and Present

January 26, 1952

Gustaf E. Lindskog, M.D., professor of surgery, Yale University School of Medicine

Surgical Lesions of the Diaphragm

February 2, 1952

Benjamin Spector, M.D., professor of anatomy and professor of history of medicine, Tufts College Medical School

The Anatomico-physiologic Mechanisms Underlying Abdominal Pain

February 9, 1952

Averill A. Liebow, M.D., professor of pathology, Yale University School of Medicine

Clinical Pathological Conference

February 16, 1952

Milton J. E. Senn, M.D., professor of pediatrics and psychiatry, Yale University School of Medicine

Pediatric psychiatry

February 23, 1952

Renato A. Ricca, M.D., assistant staff physician, Hartford Hospital

Cellular physiology

March 1, 1952

Thomas M. Durant, M.D., professor of clinical medicine, Temple University School of Medicine

The Anginal Syndrome

CONNECTICUT VA MEDICAL SOCIETY

The medical conferences of the Connecticut Veterans Administration Medical Society will be held during January 1952, at 3:30 P. M., on the dates listed below, at 95 Pearl Street, Hartford, except meeting of January 31.

January 3

Joseph Brandriss, M.D., chief EENT, VA Regional Office, Hartford

Endoscopy in Diagnosis and Treatment (continued from previous talk on same subject)

January 17

Benjamin B. Whitcomb, M.D., chief surgeon, Hartford Hospital

Psychosurgery

January 31

Alfred Hurwitz, M.D., chief of surgical service, VA Hospital, Newington, at the Society's round table dinner meeting at Heublein Hotel, Hartford, at 6 o'clock in the evening, followed by the speaker at 7 o'clock

A New Approach Into Fluid and Electrolyte Therapy

U. S. NAVAL RESERVE VOLUNTEER MEDICAL UNIT

The U. S. Naval Reserve Volunteer Medical Unit 3-1 will hold the following scheduled meetings during the next quarter:

January 14

The Medical Officer's Duties in the Organized Reserve

Lt. L. M. Davey, MC-USNR

January 28

Problems of the Flight Surgeon

CDR. William James MC-USN

February 11

Submarine Medical Problems

Lt. Francis Reilly MC-USNR

February 25

An Analysis of 8500 Cases returned to the U. S. from USN MOB No. 4, New Zealand

Capt. Denis S. O'Connor MC-USNR

DAIRY PRODUCTS *Essential* TO WINTER DIETS



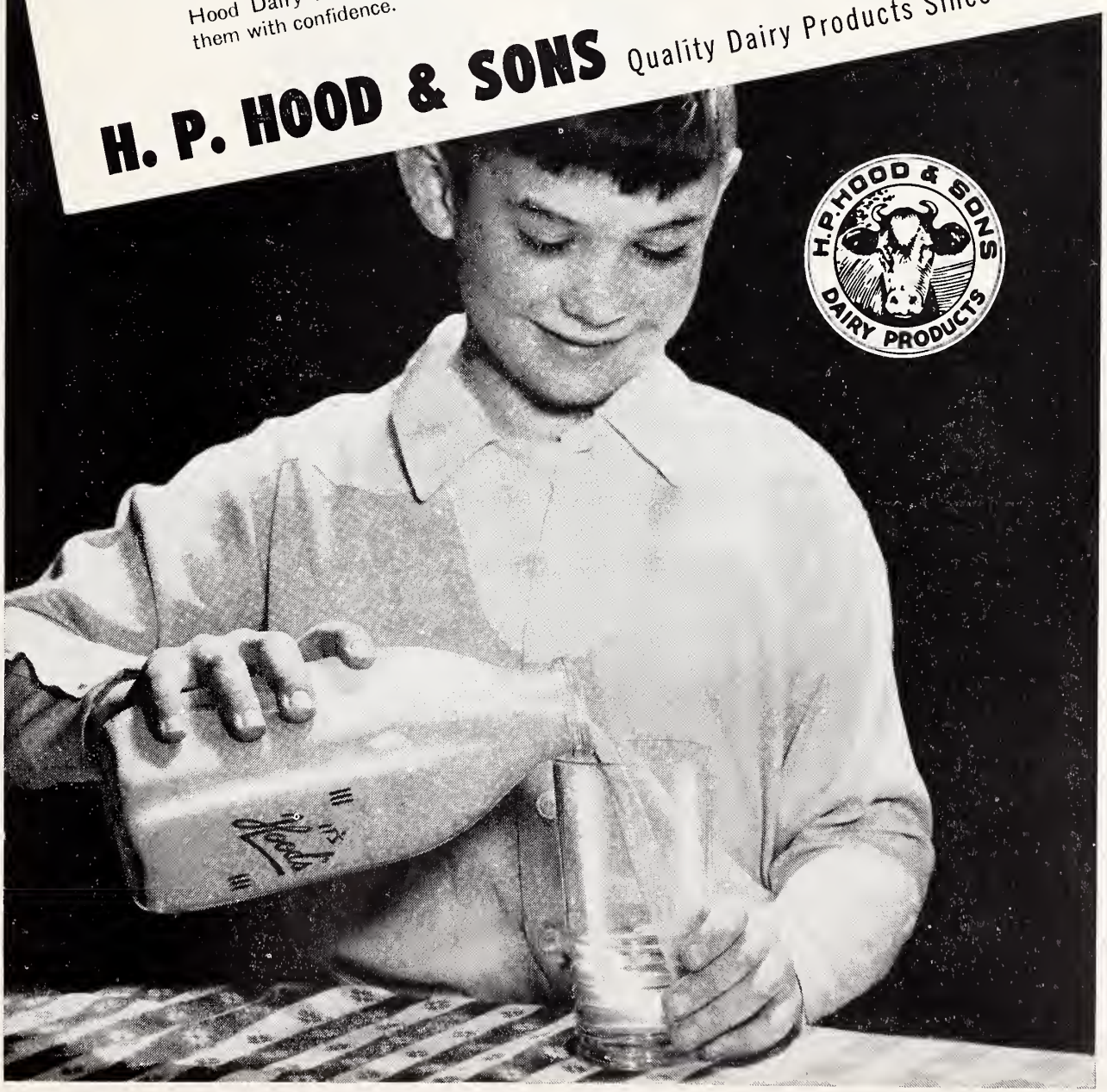
Doctors, above all people, know how important good dairy products are to good health. Nutrition-rich milk and other dairy products provide carbohydrates and fat for the body heat and energy that are so important during cold, frequently sun-less weather.

For 106 years, H. P. Hood & Sons have been famous for distributing the finest in dairy products. Hood's quality-control program begins on the farm and maintains rigid protective measures all along the line . . . right to the housewife's refrigerator. This rigid quality-control program assures constant purity and flavor richness.



Hood Dairy Products help build good health. You can recommend them with confidence.

H. P. HOOD & SONS Quality Dairy Products Since 1846



March 10

The Medical Officer with the USMC

Speaker to be announced

March 24

Medical Officer's Duties with the SeaBees

Lt. L. M. Davey, MC-USNR

Appropriate moving pictures for the above subjects are to be available. Since some of them are still on the "restricted" list, it will be necessary for any interested Service Personnel to bring proper identification with them before they can attend such showings.

Requests for removal from the "Inactive Status List" and reassignment to more active participation in the training program can be processed for such officers as may desire to again accumulate retirement and promotion points.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1952 ESSAY CONTEST

The Twelfth Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1952. The Society will offer a cash prize of $200, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association and residents and citizens of the United States. The winner will be invited to present his contribution before the 17th Annual Meeting of the Mississippi Valley Medical Society to be held in St. Louis, Missouri, October 1, 2, 3, 1952, the Society reserving the exclusive right to first publish the essay in its official publication—the Mississippi Valley Medical Journal (incorporating the Radiologic Review). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1952. The winning essays in the 1950 contest appeared in the January 1951 issue of the Mississippi Valley Medical Journal (Quincy, Ill.).

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Bldg., Quincy, Ill.

STAMFORD ACADEMY OF GENERAL PRACTICE

The Stamford Academy of General Practice will sponsor a Post-Graduate Course in Endocrinology and Diseases of Metabolism.

The course is to be given by distinguished members of the Faculty of the Yale Medical School.

It will be held on Tuesday evenings, weekly, except for the second Tuesday of each month, at the Auditorium of the Stamford Hospital at 8:30 P. M.

The First Lecture on January 22, 1952, will be given by Dr. C. N. H. Long, Dean of the Yale Medical School. His subject will be "The Pituitary-Adrenal Axis."

Interested physicians may obtain further information by writing to Dr. Arthur Koffler, Secretary of the Stamford Academy of General Practice, 218 Bedford Street, Stamford, Connecticut.

LETTERS TO THE EDITOR

Dear Editor:

The men of medicine have conquered typhoid, smallpox, diphtheria, many other diseases. They have been victorious in their "know how;" they possess basic understanding, they have applied their knowledge, mastered many techniques, and have helped man in his search for health and happiness. They have kept the faith.

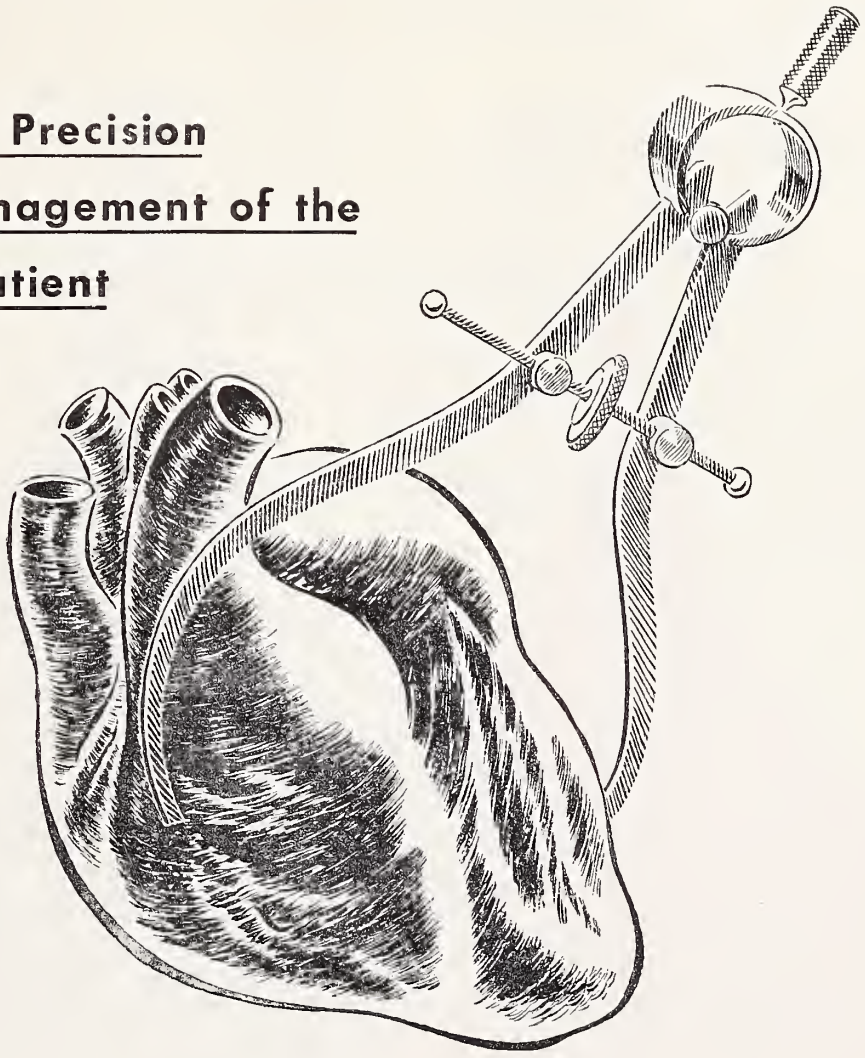
The men of medicine are engaged in a new adventure; maintaining the American way of life, upholding the dignity and integrity of human personality, preserving the infinite worth of human life, and helping man to preserve for all time the inherent right of freedom of choice.

These democratic principles are now at stake. The boundaries of the rights of individuals are being narrowed, freedom of expression is only freely granted within the limits of status quo, the range of freedom of choice is being restricted by predetermined decisions, and the life of the American people is being regimented. Surely, our leaders are not keeping the faith.

The task of the medical profession can no longer be limited to healing the sick, preventing the socialization of medicine, and keeping itself free from governmental interference. It must exert its influence, its power, its organization, in maintaining the basic freedoms that have made America a good place to live, to move and have our being. Seen in a larger perspective, the progress of America has been phenomenal. We must be vigilant, militant, continue to keep an open mind, a suspended judgment, and recognize there is yet more truth and light to break forth. As a profession, as citizens, we have a job to do. Let us keep the faith.

Arnold Friesen, M.D.,
Madison, Connecticut

To Assure Precision
in the management of the
cardiac patient



PURODIGIN offers the advantages of:

- a crystalline product of uniform potency,
- fully active by mouth;
- supplied in graduated potencies
- to facilitate dosage to meet the needs of the individual patient.

TABLETS OF: 0.05, 0.1, 0.15 and 0.2 mg.

PURODIGIN®

CRYSTALLINE DIGITOXIN, WYETH

Wyeth®

Wyeth Incorporated, Philadelphia 2, Pa.

NEWS
from County Associations

Fairfield

The annual meeting of the Bridgeport Medical Association was held at the Bridgeport Hospital auditorium on the evening of December 4, Arthur Sekerak presiding. Dr. Charles K. Friedberg, associate attending physician at Mt. Sinai Hospital in New York and lecturer in medicine at Columbia University presented a paper on "Changing Concepts and Technics in the Management of Congestive Heart Failure." During the business meeting, Elwood C. Weise, Sr., chairman of the Nominating Committee presented the following slate of officers for the year 1952: President, Mark A. Gildea; President-elect, Owen J. Groark; Vice-President, John F. Nolan; Treasurer, Joseph G. Hennessey and Secretary, Albert Levenson. This slate was approved and will assume office at the time of the annual banquet to be held at the Algonquin Club in Bridgeport on the night of January 15. Edward P. Kemp retired as treasurer and Joseph J. Esposito retired as secretary. In Dr. Esposito's report as secretary he touched on the accomplishments of the Association in the past year, especially the establishment of an emergency Panel of Physicians to answer calls, the work of members in the program for treatment of poliomyelitis, the listing of physicians according to their specialties in the telephone directory, and the establishment of the clinic of the Bridgeport Heart Association and the Arthritis Foundation. Edward Wasserman was admitted to membership in the Association at the meeting.

Attending the meeting of the Radiological Society of North America in Chicago in December were Russell A. Keddy of Stamford and Joseph J. Esposito of Bridgeport.

One of the most successful seminars ever held in Bridgeport took place under the auspices of the Bridgeport Heart Association and cosponsored by the Bridgeport Medical Association and the Fairfield County Medical Association at the auditorium of the Bridgeport Hospital, December 5. Over 150 physicians attended the all-day seminar. The morning session at which Marcus Backer presided presented papers by William Resnik of Stamford who spoke on "Angina Pectoris," H. M. Marvin of New Haven who talked on "The Management of Coronary Thrombosis," Henry Dolger of Mt. Sinai Hospital in New York whose paper was entitled, "Diabetes and Vascular Disease," and Harry M. Zimmerman of Columbia University and Montefiiore Hospital in New York who spoke on "Cerebral Vascular Disease." Luncheon was served at the hospital to all attending physicians. The afternoon session was under the direction of I. Sidney Zaur and papers were given by George A. Perera of Columbia University on "Hypertensive Vascular Disease;" Stewart G. Wolf of Cornell University Medical College on "Psychomatic Aspects of Heart Disease;" Ruth Whittemore of New Haven on "Congenital Heart Disease;" Louis H. Nahum on "Cardiac Drugs" and A. Wilbur Duryee of Post Graduate School of Medicine in New York "Occlusive Arterial Disease." The success of this seminar was due almost entirely to the untiring efforts of the program chairman of the Bridgeport Heart Association, Sidney L. Penner of Stratford.

Hartford

The new president of the medical and surgical staff of St. Francis Hospital, Hartford for the coming year is Thomas P. Moylan. John F. McDermott was chosen president-elect. Re-elected to staff offices were Thomas F. Murphy, secretary; John E. Franco, assistant secretary; and Timothy L. Curran, treasurer.

At the Hartford Hospital annual meeting of the medical and surgical staff, Stanley B. Weld was re-elected president and Arthur C. Unsworth, secretary. The new vice-president is E. Myles Standish and Ralph T. Ogden was elected chairman of the executive committee.

Eliot S. Cogswell of Hartford was married on November 8 in Bridgeport to Ruth S. Hall. Dr. Cogswell has practised in Hartford for 40 years.

Charles C. Yerbury of Enfield was the only official observer from Connecticut attending the World Medical Assembly in Stockholm in September 1951. There were forty physicians of the U. C. Committee in attendance.

Paul Kunkel, chief of medical service at the Newington Veterans Hospital, has been appointed chairman of the Cardiac Clinic Committee of the Connecticut Heart Association. The purpose of this committee is to work toward the improvement of all cardiac clinics and review application for approval of clinics and make recommendations to the

Only Terramycin *in Oral Drops*

offers *all* these advantages

1

convenience of a liquid concentrate

Crystalline Terramycin Hydrochloride Oral Drops provide 200 mg. per cc., 50 mg. in each 9 drops—the only broad-spectrum antibiotic available as a liquid concentrate affording optimal convenience and flexibility in dosage schedules.

2

miscibility with foods and fluids

Terramycin Oral Drops are miscible with most foods, milk and fruit juices; can be taken "as is" or mixed. Potent oral drops offer rapid broad-spectrum antibiotic activity in a form permitting the utmost simplicity in the therapeutic regimen.

3

pure crystalline compound—well tolerated

Terramycin Oral Drops are prepared from pure crystalline material, free of impurities which may contribute to adverse reactions.

supplied:

2.0 Gm. with 10 cc. of diluent, and specially calibrated dropper.

ANTIBIOTIC DIVISION Pfizer CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

National Office regarding approval of cardiac clinics in Connecticut.

Middlesex

New opportunities for postgraduate training are being offered through an increased educational schedule. At present there is a Tumor Clinic which meets the first Wednesday of each month at 9:30 A. M. There is a Cardiac Clinic which meets the second and fourth Tuesday of each month at 9:30 A. M. There is a Clinical Conference which meets each Friday at noon. There are Clinical Pathological Conferences which alternate with Chest Conferences on Mondays at noon.

All these meetings are held at the Middlesex Hospital. The Central Medical Association has its meetings on the second Monday evening of each month. At these meetings a speaker on a professional topic is usually present. They alternate between the Middlesex Hospital and the Connecticut State Hospital. All physicians are welcome to attend and to participate in these programs.

New Haven

Albert Snoke, physician-administrator at Grace-New Haven Hospital, has been appointed to the U. S. Public Health Service Federal Hospital Council.

Dr. Charles H. Wilson of the Yale School of Public Health and Dr. Mildred Stanton of the State Department of Education have been appointed chairman and vice-chairman of the revised State Education Committee of the Connecticut Heart Association. Regional meetings are being held with chapter representatives to determine specific objectives of a chapter's educational program.

New London

The New London County Chapter of the American Academy of General Practice has sponsored a postgraduate course in Clinical Electrocardiography conducted by Dr. Arthur J. Geiger of New Haven. Thirteen general practitioners and internists attended the ten sessions held at the Lawrence and Memorial Hospital in New London during September and October. The course concluded with a final lecture entitled "Pitfalls in Electrocardiography" given by Dr. Harold Marvin of New Haven.

The following physicians participated in the course: John Satti, Thomas Soltz, Harold Irwin, Richard Starr, Saul Karpel, Morris Sulman from New London; Erich Goldmeier, Groton; Roger Fowler, Mystic; Harold Duennebier, Niantic; Harold Von Glahn, Old Lyme; Irving Friedman, Colchester; Frank Miselis, Uncasville; John Supliciki, Norwich.

NEW BOOKS IN REVIEW

FRONTAL LOBOTOMY AND AFFECTIVE BEHAVIOR By John F. Fulton, M.D. *New York: W. W. Norton & Co., Inc.* 1951. 159 pp. $3.

Reviewed by FRANCIS J. BRACELAND

For the second successive year the Salmon lectures have dealt with the problem of neural organization in behavior. The two volumes, the first by Stanly Cobb in 1949 and the present one by the distinguished John F. Fulton, might well be read as a unit for they complement one another.

In the present work the author reviews the historical background, the psychobiological approach and the present day knowledge of the structure and function of the central nervous system and the various interactions between specific areas of the cerebral cortex. He outlines the newer behavioral studies recently carried out on primates and, in Chapter 3 of his book, makes available much hitherto unpublished data. He then discusses the bearing of this experimental work upon the problem of frontal lobotomy in man.

In the light of information now at hand Dr. Fulton concludes that the radical lobotomy as done by Freeman and Watts and by Lyerly should be supplanted by a more selective procedure which will alleviate mental symptoms but will avoid the undesirable reactions which sometimes followed in the wake of the more radical procedures. He believes that Grantham's method of section of the medial ventral quadrant by electrocoagulation has much to recommend it.

Because these findings are recent, further evaluation will of course be required before authoritative statements can be made. The lectures were given and the book written in order to stimulate further thought, provoke discussion, and encourage experimentation rather than to furnish a guide to clinical practice. If the book is read with this in mind the reader will be in for an interesting evening and will benefit by being brought up to date with the more recent experimental work in the field of psychosurgery.

THE 1950 YEAR BOOK OF MEDICINE (May, 1949-May, 1950). *Edited by Paul B. Beeson*, M.D., *J. Burns Amberson*, M.D., *William B. Castle*, M.D., S.M. (Hon.) Yale, M.D., (Hon.) Utrecht, *Tinsley R. Harrison*, M.D., *George B. Eusterman*, M.D. *Chicago: The Year Book Publishers.* 1950. 819 pp. $5.

Reviewed by ALLAN K. POOLE

The Year Book of Medicine which is always a valuable book, is even more so for this year. Each section includes a review of progress of the past decade, which is a forcible reminder of the dramatic changes prloduced in many fields.

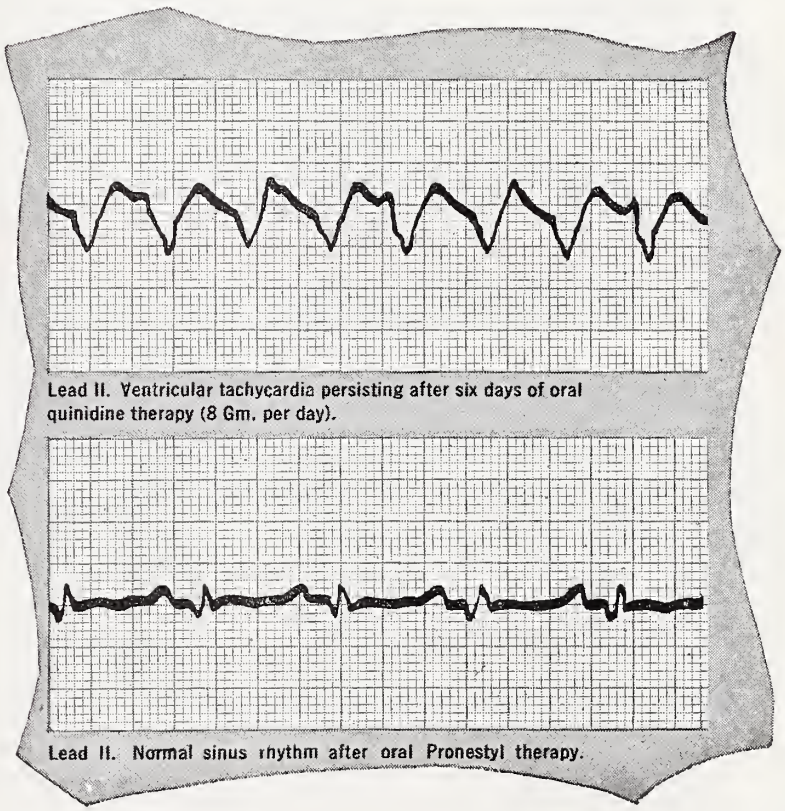
The book is very well edited and the abstracts are concise and clear. It is difficult to pick out any one section for praise when all are so good.

The Editorial Board has done an excellent job.

a new drug . . .
for the treatment of ventricular arrhythmias

PRONESTYL *Hydrochloride*

Squibb Procaine Amide Hydrochloride



Lead II. Ventricular tachycardia persisting after six days of oral quinidine therapy (8 Gm. per day).

Lead II. Normal sinus rhythm after oral Pronestyl therapy.

Oral administration of Pronestyl is indicated in ventricular tachycardia and runs of ventricular extrasystoles. Intravenous administration is sometimes used in ventricular tachycardia and to correct ventricular arrhythmias during anesthesia. For detailed information on dosage and administration, write for literature or ask your Squibb Professional Service Representative.

PRONESTYL IS A TRADEMARK OF E. R. SQUIBB & SONS

Pronestyl Hydrochloride Capsules, 0.25 Gm., bottles of 100 and 1000.
Pronestyl Hydrochloride Solution, 100 mg. per cc., 10 cc. vials.

SQUIBB MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.



24 hour anticoagulant action

A single, deep, subcutaneous injection of 30,000 to 40,000 U.S.P. units (approximately 300 to 400 mg.) of Depo*-Heparin "will give a lengthened coagulation time of 2 to 4 times normal for about 24 hours."[1]

This advance in the management of thromboembolic phenomena such as coronary artery disease and thrombophlebitis, was made possible through investigations by Upjohn and other medical researchers which led to the development of Depo-Heparin.

Depo-Heparin

Depo-Heparin Sodium is available in 1 cc. size cartridges with disposable syringe. Each cc. contains:

Heparin Sodium	20,000 U.S.P. units (approximately 200 mg.)
Gelatin	180 mg.
Dextrose Anhydrous	80 mg.

Water for injection q.s.

Preserved with sodium ethyl mercuri thiosalicylate 1:10,000

1. *Smiles, William J.: Long-Acting Heparin Preparation: A Useful Adjunct in Anticoagulant Therapy. U. S. Armed Forces Med. J., Vol. II., No. 1 (Jan.) 1951.*

Trademark, Reg. U. S. Pat. Off.

Upjohn Research

for Medicine... Produced with care... Designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

Table of Contents : February 1952

Medical Education in the Present Emergency
Samuel C. Harvey, M.D., New Haven 73

Is Duodenal Ulcer Hereditary?
Christopher J. McCormack, M.D., and Maurice W. Kearney, M.D., Hartford 82

Torula Infection of the Central Nervous System
Edward Wasserman, M.D., Bridgeport 85

Adrenocortical Extract in Pediatrics William Provenzano, M.D., Cambridge, Mass. 89

The Narcotics Problem in Connecticut Daniel P. Griffin, M.D., Bridgeport 91

Professional Relations in Medical Care Insurance
Thomas J. Danaher, M.D., Torrington 96

EDITORIALS

The Medical Education Study Commission 98
CMS For Physicians 98
The Connecticut Chapter Arthritis and Rheumatism Foundation 99
Medical Education in the Present Emergency 99

DEPARTMENTS

Progress in Clinical Medicine
Nonspecific Benign Pericarditis
William F. Prestley, M.D., Hartford 100
The President's Page 103
The Secretary's Office 104
The Historian's Note Book
A Review of "An Early American Experiment in Socialized Medicine," by Everett S. Brown
Arthur S. Brackett, M.D., Bristol 108
Letters to the Editor 114
Public Relations 115
News From Washington 120
State Department of Health
Procedures for Prevention of Rheumatic Fever by Penicillin Prophylaxis 123
From Our Exchanges 125
Woman's Auxiliary 129
Our Neighbors 134
News From County Associations 134
News From Yale University School of Medicine 136
New Books in Review 136

MISCELLANEOUS

A Study of Blue Cross Coverage and Hospital Charges 109
Preventive Aspects of Chronic Disease, A Public Responsibility 112
The Doctor's Office 114
Obituary
Robert Corwin Sellew, Sr., M.D. 128
Special Notices 130
Charter and By-Laws
Connecticut State Medical Society 140

On January 14, 1952, payment was made on Claim #91980, a Caesarean Section, to make a total of

Five Million Dollars

paid to Connecticut Physicians since April 1, 1949. Currently, CMS pays Connecticut Physicians $284,000 each month.

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI FEBRUARY, 1952 No. 2

MEDICAL EDUCATION IN THE PRESENT EMERGENCY

SAMUEL C. HARVEY, M.D., *New Haven*

WE meet this year in troublous times, in an atmosphere of crisis and emergency, with men and material being mobilized for purposes of war, now of attrition, but sooner or later perhaps of world-wide combat. There is no question in our minds of the final outcome, nor is there of the willingness to endure the hardships necessary to achieve this. To this we again "dedicate our lives, our fortunes and our sacred honor."

We consider ourselves a peaceful nation and are astonished rather than resentful at being called "warmongers" and "aggressive imperialists," yet in the 175 years since the Declaration of Independence we have been engaged in seven major conflicts. Of these, two—the Spanish and Mexican wars—may have been at their inception tainted with "imperialism" but the eventual outcome of each scarcely conforms to this description. Three—the Revolution, the War of 1812, and the War Between the States—were in a sense internecine and fought on basic issues of a constitutional nature; they would not have been totally destructive of our safety and welfare had they been decided other than was the case. Only World Wars I and II and this cold conflict—all three historically will probably be considered as one—involve such fundamental values that defeat would mean a total disaster, not only to our civilization but also to that of the world as a whole. This catastrophe would only be comparable to the fall of the Roman Empire together with the disintegration of the Greek civilization, followed by one thousand years of barbarian unenlightenment and disorder—the so-called Dark Ages.

Of these 175 years, 153 have been passed in peace and 22 in war. Only three of these conflicts have lasted beyond two years; the Revolution six, the War Between the States four and the Second World War four; only in these has our social and economic polity been seriously disturbed, and then but temporarily. So far we have been able to improvise, to retrieve initial disaster, and to achieve victory, but in truth, as a nation, we have never had to undertake the long haul that would thoroughly test our tenacity, the soundness of our societal order, and the ability of our form of government to meet the necessities for survival under the conditions of prolonged war.

War of such magnitude and length has been in the past, according to Toynbee, the proximate cause of the downfall of many civilizations. Certainly it has always resulted in profound changes of such a nature that it were only excusable when defeat would have been a greater calamity. Nevertheless, even in victory, these prolonged conflicts have ended with the exhaustion of morale and the material resources of the combatants, the one having the greatest tenacity and ability to fully mobilize his potential strength finally winning the battle, or at least achieving a stalemate. Under such duress, orders of government have been changed, societal polity and economy profoundly disturbed, and the progress of civilization set back in many instances for years.

The present period of conflict is not one that can be brought to a conclusion by a decisive battle or campaign, for neither side will commit itself to the issue unless it be reasonably sure of success, or is forced in desperation by an impending collapse to take the risk. Therefore, in all probability it will be one of attrition, accompanied by limited explorations in force, both diplomatic and military; that is

Presidential address given before the American Surgical Association, Washington, D. C., April 12, 1951
Published in Annals of Surgery 134:289 September 1951; Reprinted by permission, J. B. Lippincott Company

to say, a prolonged contest in which the rival forms of government, of societal organizations and economics, and of civilizations will be put to a lengthy and searching test.

The Marx-Lenin-Stalin dogmata as to this situation have been spread on the written page; not only the objectives of the conflict but also the means of accomplishing these are there and the successive steps indicated. The philosophy and projected maneuvers are so incredible and so fantastic, that, like Hitler's program in *Mein Kampf*, it is hard for many to take these statements as anything other than the irresponsible and irrational cogitations of unbalanced minds. And so they are, but civilizations have been destroyed or profoundly altered by such as these in the past and, it would seem, may continue to be. The contest is between spiritual values and complete irreligion; government by the people and that by a totalitarian dictatorship; an economy stimulatingly competitive and one planned by a self-selected governing group, brutally enforced; and individual freedom of speech and expression as against rigid censorship and control. It is the conviction and prediction of Marx and his disciples that under the strain of this conflict, whether of attrition or by battle, "imperialistic capitalism" will collapse and be replaced by communism as it has been developed in the Soviet. In fact, it is the fixedness of this belief in the eventual outcome that makes unlikely a direct and immediate attack by military force, although every effort short of this is being employed to precipitate the anticipated result.

Our problem is that of preparing for all-out war and at the same time maintaining and, if possible, improving our present advancing civilization. Complete and exclusive concentration upon this entails the deviation of all manpower and material resources to this end, and if the objective of the combat is achieved shortly, the exhaustion of these is remedied in the succeeding years of peace. In a war of prolonged attrition, however, it is essential that these resources be not exhausted but rather increased and that evolution continue in the further development of our civilization. That a balance must be maintained between the requirements of the armed forces and those of civilian life is generally agreed upon, but the means of achieving this balance, and the relative proportions involved, are subject to debate and must be formulated with the greatest of care.

The Fellows of this Association are necessarily deeply concerned not only in the provision of the armed forces with an adequate number of physicians but also in the maintenance of adequate medical care in the civilian population. Both of these requisites, in a long drawn-out conflict by attrition, demand a continuing flow of students through the schools of medicine, sufficient in number and of high quality. The accomplishment of this during a time of prolonged stress, such as we face, requires a thorough understanding of the problems involved and a sound approach to their solution.

Some 40 years ago an intensive study was made by a committee of the American Medical Association of the deplorable over-all picture as regards the medical schools in the United States. At approximately the same time the Carnegie Foundation for the Advancement of Teaching carried out an extensive survey, the results of which appeared in the devastating Flexner report.[1] These, and particularly the latter, caused the closing of around one half of the so-called medical schools then in existence. Most of these were completely or nearly proprietary in the sense that they were dependent, so far as finances were concerned, upon tuition fees. Many were disassociated from university control in respect to educational standards, and in many others the affiliation was largely titular and involved no financial support from the mother institution or even parental advice.

As a consequence of dependence upon tuition fees, enrollment beyond the capacity of the faculty for adequate teaching occurred and methods of teaching were encouraged which enabled it to handle the largest possible number of students with the least expenditure of time and effort. Moreover, the fees were used, for the most part, not in the provision of physical facilities, such as laboratories, or for purposes of clinical teaching at the bedside, but in the remuneration of the individual members of the faculty whose primary responsibility and source of livelihood was that of practice. As a result of this, teaching for the most part was carried on by lectures and clinical demonstrations; all that was needed was a lecture hall or amphitheater, the size determining the number of students that could be enrolled in the school. When this was associated with the treatment of the patient in the operating room, then the acme of economy of time for the teacher was achieved and the "operating theater" therefore became an established feature.

The recommendations of Flexner were, in general, that the schools of medicine and their constituent

departments be raised in concept and in practice to a university level which could be best achieved by bringing them under the financial and educational responsibility and control of institutions of higher learning. He emphasized that this involved the development of faculties whose primary and dominant interest was that of the education of the medical student. The improvement of the quality of teaching required the bringing of the student from the lecture hall and clinical theater into the laboratories and the wards. In order to do this, it was necessary to break down the class-mass into groups, the number of which was in direct relationship to the facilities required. Under these proper conditions the student then did his own dissection, carried out his own demonstration experimentally in the laboratory, and studied at first hand the gross and histologic pathology in the preclinical years. In the clinical experience, instead of presenting one or two instances of disease a week in the amphitheater, or listening to the professors do so, he had the run of the ward and intimate contact with many patients whose diagnosis and care were in part his responsibility. In both the laboratories and the wards he had not so much dogmatic and authoritative indoctrination as an opportunity to learn, and the teachers in their daily activities set an example of learning themselves. Therefore it was necessary that they be inquisitive, skeptical of established doctrine, and constantly searching for further knowledge, that is to say, active in research.

A very considerable improvement in the quality of teaching has, as a result, taken place in both the undergraduate and the postdoctoral years of education in medicine, sufficient at least to establish the validity of Flexner's thesis. The need for laboratories and clinical facilities has been commonly accepted and to a considerable degree provided, although they are by no means even now adequate in many schools, and in others only relatively so. That university standards of education should obtain and that the responsible faculties in schools of medicine should have teaching as their primary and dominant function is no longer a moot question. As a result of all this, medical education on this continent has become, since World War I, preeminent. The problem today is to keep it so.

There have been, however, certain innate difficulties in this shotgun wedding of the universities and the schools of medicine. Some of these, and perhaps not the least weighty, are intangible and can only be understood when considered historically. The university arose in the early middle ages by the recognition of certain established institutions of higher learning which, as corporate bodies, were enabled to confer the degrees of the baccalaureate, master and doctor. These were in the beginning authoritatively designated by the Pope, and those bearing these degrees were then qualified as teachers so far as his authority ran. The first university was at Salerno and arose from organized teaching in medicine, as did, somewhat later, those of Montpelier and Padua. Bologna was initially a school of law, and Paris of divinity and philosophy. These were associated with the revival of learning and the study of the Latin, Greek and Arabic books that came to be known as classics, and scholars and teachers were developed whose knowledge and skills lay in the ability to read and write the classical languages. This was, without necessarily any reference to the highly special fields of medicine, law, divinity and even philosophy; thus the teachers were known as humanists, or classical scholars. In the towns of Cambridge and Oxford were developed collegia of students and teachers, the latter largely derived from Paris, and thus these colleges became centers for a classical culture.

The first teachers in the United States of the "higher learning" were divines who had received their education at Cambridge. Therefore they established colleges modeled after that institution, having the same classical curriculum. At Harvard 150 years passed before a medical school was initiated; and at Yale a century, while schools of divinity and law came still later. The colleges were and still are, to a very considerable degree, humanistic and under the influence of Oxford and Cambridge. The graduate schools of our universities in which the degree of Doctor of Philosophy is conferred, the schools and institutes of science, and the schools of medicine, have their origin elsewhere, mostly from the continental universities of Europe and to a very major degree from those in Germany. There are then in our universities, traditionally and philosophically, two areas of education, the one represented by the undergraduate college leading to the baccalaureate degree, topped by the graduate school with its masters and doctors of philosophy, and the other, represented by graduate schools in the learned professions and in science which confer comparable degrees relevant to the three particular fields. It is not remarkable that with this conflict between two large zones of interest the attempt to meld these

seems at times to lead to an institutional schizophrenia.

Unfortunately this dichotomy is reflected in the loyalties of the alumni. The graduates of the colleges, of whom only a relatively small number continue their education at a higher level either in their own institutions or elsewhere, have a primitive and almost exclusive interest in the undergraduate schools, rather than in the university as a whole. Indeed, the majority have no understanding of what a university is or should be, and inasmuch as the financial resources of the institution are derived, in large part, either directly or indirectly from the alumni they view with a jaundiced eye the relatively large budgets that are required for the development and substance of the schools of a higher level.

This attitude is important for the schools of medicine inasmuch as they require very substantial financial support from the general funds of the university, or from specific endowment obtained from the alumni, or from outside philanthropic or governmental agencies susceptible to their influence. To make the situation still more difficult, there lingers the tradition of the self-supporting proprietary school which budgeted itself largely by means of tuition fees, as in fact the schools of law and divinity today do to a very considerable degree, these not incurring the costs of sustaining laboratories but carrying out their teaching in large part by didactic methods.

There is some justification for reluctance on the part of the university when it faces the cost of educating the medical student relative to that of those elsewhere within it. It may be roughly estimated that the modern school of medicine, with a student body of 75 in a class, requires a physical plant that when properly equipped costs around eight to 12 million dollars and an endowment of some 20 million dollars to provide an annual budget of one and a quarter million dollars. According to a report of Dean Hinsey,[2] it needs a faculty of about 60 full-time salaried teachers in order to meet the average ratio of one teacher to five students for the existing 78 schools. The over-all cost per student is in the order of 4,000 dollars, of which approximately only 20 per cent is covered by the charges for tuition.

There are in the 78 medical schools in the United States some 26,600 medical students, which gives a mean of 85 per class per school. It appears then that a minimum of 50 would represent the minimum level and that of 125 the maximum. The Good-enough report,[3] largely based on a study of these same schools, suggests that the maximum, as regards economy and effectiveness of medical education in a school, is 100 students. If this is true, the mean would be 75, which suggests, as compared with the actual 85, that there is already an appreciable overloading of the existing medical schools, arising in part from the increased emergency enrollment resulting from World War II that has persisted, as such innovations usually do. The mean before this increment was 73.5, and a second increase now proposed and being put into effect by many schools, will bring this to just under 100, the over-all range being from 50 to 150.

That this will have an unfavorable effect upon the quality of medical education cannot be seriously questioned. Mark Hopkins on one end of a log and 150 students on the other presents an insurmountable problem save by having enough teachers of high caliber to split the mass into workable groups of, say, ten and with equivalent physical facilities.

The apparently large cost factors can be justified only by the quality of the teaching obtained. That, in elementary science in the college years, is much more expensive than that of the humanities, and in the graduate schools of science undoubtedly very much greater than in the humanities at the same level when computed on a student per capita basis.

The medical school is, of course, a graduate school having to do with the biology of man and requiring four years for the doctorate. It unfortunately but inevitably appears to be the most costly unit in the university—some $16,000 for each graduate of it. Of this, however, the student pays $3,000. The university today expends practically none of its own funds for research, the money being obtained through grants from outside agencies. Were it not for this there would be but little or no research, or the university would have to underwrite it out of its own funds. Under the latter circumstances, and were this charged against the costs of the teaching, one-eighth of the expense would be reasonable, or $2,000 per student. This leaves, then, $11,000 for the university to underwrite on a basis comparable to its other students, or $2,750 per year for each student, which is about twice that of the over-all university student population, 75 per cent of which are at the college level. This does not seem an unreasonable differential; it is nevertheless a constant source of criticism and dispute, so much so that the univer-

sities and the medical schools alike earnestly desire that medical education become in some way financially autonomous.

To accomplish this involves several possibilities. One of these is the increase in endowment specifically assigned to the school of medicine. This in theory is the more desirable, but is at present a slow process and in the recent past has not increased the funds actually available for expenditure, because of a lowered interest rate together with the depreciation of the monetary unit. The university as a whole is in the same predicament and as a result hesitates to make adequate financial commitments to the school of medicine. Another remedy for this situation that is pending in Congress is subsidy from federal funds. It has been estimated that the medical schools in this country need at present some 20 million dollars each year to supplement the current budgets. Recently the American Medical Association[4] has appropriated $500,000 for the same purpose and intends to continue this annually. The former, if prorated equally to the 78 schools, would provide around $260,000 each and the latter around $6,500. It is apparent that there is a wide spread between the two, but in either case the mechanism of determining the relative needs of each school will present a problem of considerable magnitude, particularly if it is to retain its autonomy.

A common formula in the proposed federal subsidy is that of so much per student, but this, while apparently equitable, will put severe pressure on the schools to increase their enrollments; indeed this, in some tentative bills in Congress, has been heavily weighted to this end by limiting in whole or in considerable part the contribution to the support of students above the present registration. In fact, the argument for subsidy is largely that of enabling them to turn out more doctors and not that of producing better ones, or even of maintaining the present quality of medical education. It is important to ascertain the reasons for this demand and to be certain of their validity before these procedures are adopted, powerful because of their financial implications and potentially destructive of that which has been accomplished over the recent years in the teaching of medicine.

Still another approach to the resolution of the financial difficulties of the schools of medicine has been over some years in the process of an intramural development. This has the advantage of being experimental in nature and not irreversible by reason of pressure from without the institution concerned. It is essentially the utilization of the earning capacity of the faculty for the provision of funds supplementary to the budget.

In this, each member of the faculty with a primary responsibility for teaching receives his remuneration only on the basis of a salary; whatever he may obtain as a result of his professional activities accrues to the financial resources of the institution concerned, being expended directly in current budget or indirectly in enlarging its endowment funds. This corresponds to the procedures obtaining in several "group practice" organizations, where the surplus of earnings over the costs involved accrues to a philanthropic and tax-free institution, usually educational. The potential advantages of this are apparent, the disadvantages can only be learned by experience, critically examined.

The first of these is the relatively inequitable earning potential of members of the faculty. A teacher in the department of anatomy has relatively none, one in a clinical department may have much. However, an anatomist is an essential component in the teaching of the school, no less so than is the surgeon, and may be a most distinguished member of the faculty. He has the responsibility of teaching and ancillary research, or of research and ancillary teaching, but none in respect to the practice of medicine. In other words, his primary and dominant interest is exclusively that of the University while that of the surgeon may altogether too easily become the earning of monies for the support of his colleagues with his own activities in teaching and research quite subordinate. Not only does this problem exist between the clinical and preclinical divisions of schools but also with nearly equal force within the personnel of the clinical divisions, for some members of these are relatively worthless as regards the practice of medicine, while others are so accomplished that their entire time can be taken up by it. To make this sort of an organization work effectively requires not only an intelligent and understanding administration but above all a sense of team play that is beyond that at times obtaining in a faculty.

The objections that have been raised to this approach are many, some invalid and others conditional in the sense that they are susceptible of being adjusted to the circumstances. I shall only mention two which seem most important.

The first is to the effect that the institution is

indulging in the corporate practice of medicine. Perhaps this can be briefly dismissed by the statement that this has now been found acceptable for "group practice" clinics initiated to give more service with greater efficiency, the affiliation with educational institutions being secondary. The error, if there is any, lies in the adoption of this procedure initially by a school of medicine and not as an afterthought. Exploitation within the school, or by the governing body of the university, can be controlled by an alert and resolute faculty, for in the final analysis "group practice" can only be carried on if competent men can be retained under circumstances more attractive than is the case without the institution.

A second accusation is that this is "unfair practice" in that the prestige of the institution draws patients away from physicians not so connected. This complaint has been made against "group practice" not associated with philanthropic institutions and has been answered by the fact that it gives better service or it fails. The competition on this level, while controversial in the past, is not now considered unfair or unethical. When associated with an educational institution it is no more so, for its prestige likewise is dependent upon the personnel involved and the service rendered. Moreover, it has been shown again and again that a competent school of medicine in a community not only improves the quality of medicine practiced but also increases the quantitative demand for medical services without as well as within its walls.

Whether or not the financial situation as regards the schools of medicine will be remedied by this approach, or by increase of endowment and current gifts, or by governmental subsidy, is still a question. Probably, a combination of these will obtain, varying in relative weight in each school. In any case, the urgent need is that of the maintenance of the advances that have been made in the last half century in the field of medical education and the avoidance of a relapse into a quantitative production of physicians at the cost of quality.

This is a present and serious danger, for schools of medicine are being called upon for the production of more physicians to meet the needs of military and civilian defense and are being told how to go about it: namely, by increasing the enrollment, and by reinstituting the highly undesirable accelerated program adopted in the late war, the combination of the two lowering to a very considerable degree the quality of the education provided. These are the recommendations of a persuasive and well written report of the Health Resources Advisory Committee of the National Security Resources Board.[5]

The demand for more doctors is not a new one, nor has it been associated previously with the needs of defense. In the past there have been those who have seen in the provision of more doctors, a method for lowering the cost of medical care, the thesis being that as practice becomes more competitive more services will be provided at lower cost. This is based, of course, upon one of those economic generalizations which disregards the factor of quality and the psychology of the producer and consumer alike. It is assumed that competition will drive doctors into geographical areas where they are in scarcity and into lines of professional activity which should be developed, but are for some reason unattractive. We need more study of experience and more practical experimentation in the complicated field of societal relations relevant to medical care, and less of premature analysis based on insecure premises, subjected to nonrigorous mathematical interpretation, and arriving thereby at preconceived conclusions.

It is important to consider the problem of manpower in respect to physicians at the present time. Primary and obligatory is the provision of these for the armed forces. Two factors are involved, the size of these forces and the ratio of professional personnel to that of the Army, the Navy and the Air Force. The actual approved size of the armed forces as of July 1, 1951, is in the order of 3,500,000 men and there is a projected increase to 5,000,000 by 1954. In total war mobilization might reach, as it did in the late war, some 8,000,000 to 12,000,000 men. The number of these is of course controlled not only by the military necessities but by the economy of the country as a whole. We can be defeated in a prolonged conflict as thoroughly by a fiscal debacle as in battle.

The ratio of physicians to the over-all manpower of the armed forces is usually expressed in the number of physicians to 1,000 troops, and is the working basis by which the number of physicians required is arrived at. This at the moment is somewhat indeterminate, estimates varying from 3.5 to 6.5.

In the civilian population this ratio is in the order of 1.2, as obtains for the country as a whole, or 833 patients, on the average, for each physician. In metropolitan areas this may arise to 2, or 500 patients

per doctor, and in rural areas it may drop to a fraction of 0.8, or 1 to 1,250, this being generally recognized as representing a dangerously low level.

The premise is made that the present situation as a whole represents the minimum of medical care and of medical manpower. The fact is that the number of physicians in ratio to a group of population is not in itself a definitive measure of medical care. It is true of course that there cannot be adequate medical care without physicians, but it is also true that a high ratio of physicians in the population does not necessarily insure high quality or quantity of care. In fact the abundance of these may lower by reason of severe competition the standards of care, and this situation may then be interpreted as requiring the remedy of more physicians.

One knows that in metropolitan areas with congested populations and low standards of living there is the greatest concentration of physicians. An ample supply of physicians cannot in itself correct a situation in which the major deleterious factors are beyond their control—such as congestion, ignorance, low income, bad housing and subnormal standards of living. The opposite extreme is that where, instead of a congested population, there is a paucity of people relative to the area in which they dwell. Here ignorance, low income, bad housing and subnormal standards of living not only invalidate the efforts of the physician, but provide as well an environment which is unattractive to him and his family, for they cannot find there a favorable societal stratum in which they can have the satisfaction that obtains in the urban areas. Here the absence or loss of a physician may be a catastrophe, though there is little that he can professionally and personally do to correct the fundamental causes of the poor medical care, while in the city the high ratio of physicians to the population provides a reservoir or reserve which can be drawn upon in time of emergency without seriously lowering the level of it.

It is not sound then to assume that the quantity of physicians is a direct and exclusively responsible factor as regards the quality of medical care. In spite of this the premise is used that there is a necessity for the production of more physicians even though this means a lowering of quality by reason of degradation of the education of these in the schools of medicine.

As to how large this civilian reservoir may be, there is no direct and certain evidence. That it exists cannot be doubted, for any practicing physician in an urban area knows that while there are many of his colleagues overworked there are also many who are far from carrying a capacity load. Though in general this is correlated with the degree of competency or the personality of the man, it is by no means entirely so, for there is a considerable group who on entering practice are for several years working below capacity, and a large number of physicians at the age of 60 or thereabouts have a diminishing practice either by reason of choice or of being supplanted by younger men.

A highly suggestive indication of the magnitude of the reserve of medical manpower is given by the experience in the late war. Around 25 per cent of the physicians were in the armed forces. There is no statistical evidence that the health of the civilian population suffered perceptively, although it must be granted that the depreciation might be considerable before the data in respect to morbidity and mortality would significantly reflect it. Undoubtedly there was a certain amount of delay and unpleasantness, due in part to the increased tension on the part of both the patient and the physician, and less consideration of trivial and inconsequential complaints, but in the serious illnesses seen in hospital practice there was no memorable depreciation of medical care. Emphasis has been laid on the increased work incurred by the civilian physician during this time as being evidence in regard to the serious effect of the depletion of the medical manpower. It is said that "physicians were required to take on longer hours of work, extra teaching duties, to shoulder the work normally carried by interns and residents in the hospitals—all in all, to carry a back-breaking load in many instances, with tragic results to the health of the doctor."[6] Undoubtedly this was true to a certain degree and in some instances, but not beyond the call of duty in war time, willingly accepted by the profession, and is in fact further evidence for, rather than against, the presence of a reserve of manpower sufficient to maintain adequate medical care.

It should be remembered that this was an extreme mobilization for combat in which 25 per cent of the physicians were called out, while the present situation, under which these recommendations are made, is that of a partial and restricted mobilization in which the demands for physicians for the armed forces falls far below this level. This does not obviate, however, the necessity for economy and efficiency in the use of physicians in the armed forces far beyond that achieved in the last war.

At that time it was considered desirable in the tables of the organization of the army to have a ratio of 6.5 per 1,000, and while this was not achieved it was approximated. Apparently one reason for this was that this ratio was considered necessary for troops in combat and that all formations were in theory potentially combat troops. Another reason involved the logistics as regards transport of personnel, which were made difficult by the around-the-world conflict in which the theaters of battle were at distances up to 5,000 miles from this continent. Transport by ship involved weeks in active travel and arrangements for it almost equally long. It was therefore necessary to have all formations outside of the continent at a combat ratio whether in actual combat or in reserve. Within the continent there were five army commands and other echelons in which, taken together, the personnel involved was approximately of the same number as those in the combat zones, all of which were manned with physicians at the same ratio. As a result of these factors there came about a "stock piling" of physicians, a very considerable number of whom were not active or engaged in professional work. The reluctance of physicians to volunteer for commissions in the army today is in considerable part due to this experience. It is creditable and informative that objection to taking up of commissions in the armed forces does not arise because of lengthy hours of work or the unpleasant conditions under which it may be carried out, but rather because of the prospect of wasted time and the lack of an adequate professional experience.

At the present time, when combat involves a relatively small proportion of our forces and when transportation by air can take personnel anywhere in the world in 48 hours, it would seem that greater efficiency in the use of medical officers might be achieved and that a more reasonable ratio therefore might be obtained, approximating perhaps that of three physicians for 1,000, or of 3.3 in the over-all number of the armed forces. Progress toward this has been made in that the National Security Resources Board through its Health Resources Advisory Committee[5] has recommended as a reasonable ratio that of 3.7 per 1,000. Although reduction to this degree has not yet been accomplished it is implied that it may be made effective in the not too distant future.

Unfortunately, disregarding the potential resources of civilian medical manpower as demonstrated in the late war, it has been strongly recommended that the accretion of physicians for the armed forces be obtained by increased enrollment in the schools of medicine and acceleration of the teaching program. The argument for this is accentuated by pointing out the need of additional physicians in the faculties of the schools of medicine (500), in public health (2,800), in industry and rehabilitation (1,800), and in civil defense (3,300), all adding up to a total of 8,400 by 1954. These, with the requirements for the projected armed forces of 5,000,000 at a ratio of 3.7, call for some 26,900 physicians. This, in fact, would be only 14.3 per cent of the expected physician population at that time. Obviously, these could be drawn from the potential reservoir of physicians which will be available, without endangering the national safety, health and interest, and does not involve any change in the present procedures of the schools of medicine, either that of increasing the enrollment or of acceleration.

These requests of the Advisory Committee to the National Security Resources Board for additional manpower, both in the armed forces and in civilian activities, are in every respect reasonable, although the deduction that this requires an increased over-all number of physicians beyond that anticipated under the normal course of events, is not. It does not, however, indicate the means by which the prospective increase in the number of physicians required in the civilian categories will serve to meet these specific requirements. Undoubtedly an increase of 500 additional teachers in the medical faculties will be sorely needed by 1954 if the proposed program is made effective and are in fact needed at the present time. The requirement is only 0.26 of 1 per cent of the present number of physicians and it is inconceivable that the deficit is the result of lack of physician manpower. It lies, of course, in the unattractiveness of these positions which, I am afraid, will be still present in 1954. This likewise holds true in public health, and in industry and rehabilitation. In civilian defense it is understood that these 3,300 physicians required will not be devoting their full time to this and will therefore not be on a salary basis; in other words they will be volunteers. That is to say, this is an estimate of the summation of the part-time volunteer activities of many physicians or of the over-all work load equivalent to the full time of 3,300 physicians. This represents something less than 2 per cent of the present number of physicians, and even in a 40 hour a week workload, would entail

something less than one hour a week. How will these assignments be effected? Very apparently the proposed distribution into these areas cannot be achieved by anything short of obligatory action under governmental authority.

This, of course, is not proposed by the Advisory Committee, and I have no reason for supposing that it has this in mind. Nevertheless, it would be well to consider the possibilities. Under Public Law No. 779, the so-called Doctors' Draft Act, the authority is available to draft into the armed forces all physicians up to the age of 51 insofar as is consistent with the national safety, health and interest; so there is no question but that the needs of the armed forces will be met under any circumstances. With those physicians needed for the faculties of medical schools, for public health, for industry and rehabilitation and for civil defense, it is not clear what procedures may be employed for inducing physicians to undertake these assignments. These opportunities have existed for some time and are filled with difficulty or not at all, for various reasons which make them relatively unattractive to most physicians. They have, however, been endorsed by this report of an official federal agency as essential in the terms of the draft act, and deferment is urgently recommended to local Selective Service Boards for those holding positions at the present moment in these categories. The Army has in the past "loaned" medical officers on active duty to the Veterans Administration, a civilian organization not in any way a part of the armed forces. The U. S. Public Health Service has been designated as one of the services of the armed forces not under the Department of Defense, and a commission in it removes an officer from the jurisdiction of the Selective Service System. It seems entirely within the law for medical officers to be assigned wherever and whenever, in the judgment of the President, they are considered essential to the national safety, health and interest. And likewise, the power is at hand to draft the number of physicians necessary to meet these requirements.

The primary objective of this address has been to call to your attention as forcefully as possible the impending degradation of medical education by reason of inadequate financial resources, and of pressure from those responsible for budgets in the universities, as well as by the weight of governmental agencies, to the end of increasing enrollment, thus seriously lowering the quality of the teaching, and of undertaking again the three years' accelerated program which, with scarcely any exception, has been condemned on the basis of experience as materially impairing medical education. Under complete mobilization and all-out war such drastic measures might be necessary, but under the present circumstances where, over a long time, a careful balance must be maintained between civilian polity and armed defense, it is essential that education, particularly at the higher levels where it is most vulnerable to interference, be maintained secure as regards its quality.

What the citizens of this country need is more good doctors of medicine, not more poor ones; more well qualified specialists, and fewer of limited knowledge, experience and judgment; and to come closer to home, more surgeons and fewer surgical technicians. In order to have these we need not more mediocre or deficient schools of medicine, but the elevation of the standards of a considerable number of those that we have, and assurance that new schools shall be of adequate quality. And finally, we in the medical profession need at all times and critically now, not more predatory individualists but more physicians who are conscious of their responsibilities and obligations as members of a great societal group, the integrity and efficiency of which is being tested now as never before.

BIBLIOGRAPHY

1. Flexner, Abraham: Medical Education in the United States and Canada; a Report to the Carnegie Foundation for the Advancement of Teaching. New York City, 1910.

2. Hinsey, Joseph C.: Medical Education in this National Emergency. J. M. E., 26:81, 1951.

3. Goodenough, William McN.: Report of the Interdepartmental Committee on Medical Schools. London, H. M. Stationery off., 1944.

4. Editorial: Formation of the American Medical Education Foundation. J. A. M. A., 145:160, 1951.

5. Rusk, Howard A., Chairman Health Resources Advisory Committee, U. S. R. B.: Medicine, Mobilization and Manpower. Presented before Council of Medical Education and Hospitals of the American Medical Association, Chicago, February 12, 1951.

6. Barton, Paul C.: Temporary Licensure of Physicians. Papers of Ann. Congress on Med. Education, pp. 34-36, 1945.

IS DUODENAL ULCER HEREDITARY?

CHRISTOPHER J. MCCORMACK, M.D., and MAURICE W. KEARNEY, M.D., *Hartford*

Dr. McCormack. *Formerly Attending Surgeon, St. Francis Hospital, Hartford. Deceased October 6, 1950*

Dr. Kearney. *Assistant Attending Surgeon, St. Francis Hospital, Hartford*

THE performance of a subtotal gastrectomy for duodenal ulcer in the third member of one family aroused our interest again in the hereditary or familial factors involved in the etiology of duodenal ulcer.

In reviewing the literature it is very difficult to evaluate the hereditary and familial aspects of the etiology of duodenal ulcer because very few authors confine themselves to the term "duodenal." Many use the term "peptic ulcer" indiscriminately or discuss gastric and duodenal ulcers together. Some even include esophageal, marginal and jejunal ulcers and gastric carcinomas in their discussions.

Another difficulty lies in the manner in which the diagnosis of duodenal ulcer is made. Some authors require operation, others use roentgenograms and still others make a purely clinical diagnosis. Further, in accepting a family history as positive some writers confine themselves to surgically proved cases while others accept a history of indigestion or "symptoms similar to the patient" in other members of the family as positive evidence.

A few authors give complete family histories of their cases but the majority merely state that the family history is positive in a certain number of their patients not stating how many total members there were in each family. It is generally assumed that approximately ten per cent of the general population have or have had duodenal ulcer.

Eusterman and Balfour[1] wrote that the records of the Mayo Clinic show that patients with duodenal ulcer frequently report a family history of ulcer. They "have operated on two or more members of the same family often enough to gain the impression that not only is the familial incidence more frequent than is generally appreciated but that the character of the lesion and its complications is often strikingly similar in the members of a family. This is particularly true in respect to acute perforation and hemorrhage."

Hurst and Stewart[2] discuss the etiology of gastric and duodenal ulcer together and give a good review of the literature dealing with the family history. Hurst cites several families which he considers to be some of the most remarkable duodenal ulcer families he has encountered. In the first, Family A, four out of nine children had typical symptoms of duodenal ulcer; the father and two other children were dyspeptic while the mother and the remaining three children had no indigestion. In the second, Family B, the mother, all three sons, and one grandson had duodenal ulcer. In the third, Family G, the father, two out of four sons and the only daughter had gastrojejunostomy performed for duodenal ulcer. In another family of Hurst's, there were three brothers out of nine who had duodenal ulcer and one of the three sisters had recurring attacks of epigastric pain and haematemesis.

In discussing jejunal and gastrojejunal ulcers, Hurst and Stewart find a frequency of a positive family history higher than in those patients with duodenal ulcer. They discuss six patients who gave a clear family history of duodenal ulcer in two, two, three, three, three and five near relations, respectively. They conclude that "apart from definite evidence of ulcer in other members of the family, there is no doubt that patients with a gastric or duodenal ulcer give a family history of indigestion much more frequently than patients suffering from other disorders."

Riecker[3] states there is a familial incidence of "peptic ulcer in upwards of thirty per cent of the cases reported in the literature, which strongly suggests the constitutional viewpoint of the etiology of the disease." In reviewing 942 cases of duodenal ulcer, he obtained a family history of ulcer in thirteen per cent. He attributes this low percentage to carelessness of the examiner in taking the family history. Riecker does not state how the diagnosis was made in the 942 cases and accepted a positive family

history on the basis of relatives having symptoms similar to the patient.

Huddy[4] studied the family histories of 300 patients suffering from chronic upper abdominal lesions including chronic simple gastric ulcer, carcinoma of the stomach, chronic duodenal ulcer and cholycystitis. In all of his cases the diagnosis was confirmed by surgery and where necessary by further pathological investigation. However, in the family history any history of indigestion was counted as a positive case. Huddy quotes several interesting families in one of which the patient and two brothers were operated on for duodenal ulcer and another brother for gastric ulcer. In addition, there were a healthy brother and sister. He concludes that there is a distinct family tendency to these diseases, of which duodenal ulcer and cholecystitis gave the most striking family histories.

Wilkie[5] discusses duodenal ulcer in the female and mentions two families in each of which three sisters had been operated on for duodenal ulcer. He concludes that "there would appear to be an undoubted hereditary tendency to ulcer, particularly in females."

Many other writers, including Kanevsky,[6] Hunt[7] and Willcox,[8] favor the theory that it is likely that a hereditary predisposition is one of the main factors in the production of "peptic" ulcer.

Some authors agree that heredity plays a part in the etiology of "peptic" ulcer but like Smith[9] "suggest that it is hereditary habits rather than hereditary tendencies, which determine the ulcer." Held and Goldbloom[10] do not deny the familial tendency of "peptic" ulcer but propose that "the conditioned status may run through some families because of an equal mode of living."

Still other writers, Lindlau[11] and Bockus,[12] conclude that "peptic" ulcer is not inherited and that statistical studies do not indicate any greater familial incidence of "peptic" ulcer than the normal expectancy. In Lindlau's large series the incidence of "peptic" ulcer in the families of patients with "peptic" ulcer amounted to 3.7 per cent, while in the families of control patients the incidence was 2.3 per cent. This difference did not seem striking.

CASE REPORTS

We would like to present a family of six of whom the father, one son and one daughter have had subtotal gastric resections for proven duodenal ulcer, another son has a chronic active duodenal ulcer by x-ray and another daughter has epigastric distress and fatigue relieved by food. A recent gastrointestinal series on this daughter showed "duodenal irritation." The mother is now sixty-one years old, is a hypertensive but has never had any digestive complaints. The father's parents died in their eighties and the mother's parents in their seventies. None of these ancestors were known to have had any kind of indigestion.

CASE 1

Father, D. H., Sr., sixty-year old white baker, entered St. Francis Hospital on August 11, 1948 with a chief complaint of "peptic" ulcer of twenty years duration.

Present Illness—For twenty years prior to admission, the patient had been under medical treatment for ulcer; adhering to a diet, taking powders, resting sufficiently and smoking moderately.

Seven years prior to admission, he experienced a massive upper gastrointestinal hemorrhage which responded to rest, blood transfusions, Sippy diet and antacids. X-rays at this time showed a duodenal ulcer. Two years prior to admission, he was again admitted to the hospital for intractable pain but responded poorly to a strict medical regime and surgery was advised but the patient refused. X-rays showed a markedly contracted and irregular duodenal cap without obstruction. There was a pocket projecting from the apex of the duodenal cap measuring 2.5 cm. in length and 2 cm. wide at the base. This had the appearance of a perforation which had walled itself off and formed a pseudodiverticulum. He did poorly at home on his diet until just before his present admission, he could only eat bread and milk and he was readmitted for surgery.

Past History—1915—Malaria on the West Coast, advised by his physician to travel East.

Physical examination on admission showed a well developed, well nourished white male in no acute distress. The vital signs of blood pressure, temperature, pulse and respiration were: 130/88, 98.8° F., 94 and 24, respectively. Except for slight epigastric tenderness and slight abdominal distention, the remainder of the physical examination was negative. His hemoglobin was 89 per cent and urine was normal. He was given 500 cc. blood and underwent operation on the day following admission. Under continuous spinal-pentothal anesthesia a subtotal (¾) gastric resection including the ulcer bearing portion of the first part of the duodenum was performed using a posterior Polya gastrojejunostomy. The pathological report was benign duodenal ulcer.

His postoperative hospital course was uneventful. He was out of bed on the second day. The Wangensteen suction was removed on the third day and a convalescent ulcer diet started on the fourth day. His skin and tension sutures were removed on the tenth and twelfth days and he was dismissed from the hospital on the thirteenth day after surgery. Since his operation he has never had any gastrointestinal upsets and his daughter reports "he has become very sociable—a complete personality change."

CASE 2

Daughter—Mrs. R. H. D.—thirty-one year old white housewife entered St. Francis Hospital on October 20, 1948 with a chief complaint of epigastric pain—sixteen years duration.

Present Illness—Since the age of thirteen the patient has had attacks of epigastric distress, nausea, and occasional vomiting coming on chiefly after meals. The distress was relieved partly by taking food but completely by vomiting so she learned to induce this herself. She became a nurse and during training she had marked upsets and loss of weight especially when her time of duty was changed.

Four and one half years before we saw the patient, x-rays taken showed duodenal irregularity. A laparotomy at that time revealed acute catarrhal appendicitis but the stomach, duodenum and gall bladder were reported to be normal.

Following this operation her epigastric pain increased and she lost more weight.

Three and one-half years prior to admission another physician diagnosed pylorospasm and treated her with a liquid diet, luminal and brandy before meals. However, the pain continued to be intense and was only relieved by bed rest and no food.

Three years prior to admission x-rays showed a duodenal ulcer which responded well to three weeks hospitalization and a strict medical regime. Two weeks prior to admission the pain became more severe and for the first time radiated from her epigastrium to the left flank, lower thoracic region and left arm.

Past History—Three pregnancies with normal children; all pregnancies complicated by epigastric pain, nausea and vomiting.

Physical examination—on admission showed a well developed and well nourished female. Her blood pressure was 120/80 and except for slight epigastric tenderness, the remainder of the examination was negative.

A gastro-intestinal series showed an active duodenal ulcer with crater formation. Gastric analysis disclosed a fasting total acidity of 102° with free hydrochloric acid and no blood. On admission her hemoglobin was 80 per cent, red blood count 4.3 million, NPN 32, sugar 83 and urinalysis negative.

In the hospital at complete rest she failed to respond to a convalescent ulcer diet, milk, cream and Gelusil between meals and at night, tincture belladonna mXV and phenobarbital gr. ½ t.i.d. Demerol 100 mgm. was required quite frequently to control the pain.

On the thirteenth hospital day, at operation, there was found a large duodenal ulcer with considerable acute and chronic inflammatory reaction extending into the neighborhood of the common bile duct. Because of this we felt that the common duct would be endangered and a satisfactory duodenal closure could not be accomplished if we resected the ulcer. Therefore an exclusion operation was performed resecting three-fourths of the stomach and about 1 cm. of the proximal duodenum. The duodenum was then adequately closed and a posterior Polya anastamosis performed.

Her post operative course was fairly uneventful. There was some slight fever for three days. On the third day the Wangensteen suction was removed and the patient allowed out of bed. She was given liquids for several days and then changed to a Muelengracht diet. The sutures were removed on the eighth day and she was dismissed from the hospital on the thirteenth postoperative day. About one month postoperative she became pregnant and delivered a normal child without unusual gastrointestinal complaints.

CASE 3

Son—D. H., Jr.—twenty-six years old single white baker. Entered St. Francis Hospital on December 22, 1949 with a chief complaint of upper gastrointestinal hemorrhage.

Present Illness—Nine years prior to admission he was treated for nausea, fatigue and constipation but no definite diagnosis made. Six years prior to admission this patient had an attack of weakness while in the Army overseas. He was drinking wine and eating Army field rations and believed he had a hemorrhage at that time.

Four years prior to admission while still in the Army he had a massive upper gastrointestinal hemorrhage. X-rays showed a duodenal ulcer and the patient received a medical discharge from the Army. Two years prior to admission he suffered another hemorrhage and was treated in a Veterans Hospital. He responded to blood transfusions and a strict diet. Between hemorrhages he had bouts of typical ulcer pain relieved by food and milk. He smoked one package of cigarettes per day and did not imbibe in any alcoholic beverages. Three hours prior to admission he suddenly felt dizzy and nauseated and shortly thereafter vomited about 1½ pints of coffee-ground material.

Past History—negative except for ulcer.

Physical examination on admission showed a well-developed and nourished pale white male in no acute distress. The vital signs of blood pressure, temperature, pulse and respirations were 106/64, 98.6° F. and 84 and 24, respectively. There was slight epigastric tenderness but the remainder of the examination was negative.

Laboratory work on admission showed a hemoglobin of 85 per cent and red blood count of 4.35 million. He was given 500 cc. whole blood and 1500 cc. of 5 per cent glucose in normal saline; strict bed rest and only cracked ice by mouth.

The following day he was placed on a Sippy diet and three days later on a Muelengracht diet. During the first hospital week, he was given 2000 cc. of whole blood. He had several black stools but did not have another hematemesis. On the sixth hospital day his hemoglobin was 89 per cent, hematocrit 42 and his blood volume showed a deficit of 860 cc.

On the seventh hospital day a sub-total gastric (¾) resection was performed including the ulcer bearing portion of the first part of the duodenum. An anterior gastrojejunostomy was done because of a very short thick transverse mesocolon. During the surgery, performed under cyclopropane-curare anesthesia, he received 1000 cc. whole blood.

The pathological report was: Duodenal ulcer, benign, first part of duodenum.

Except for slight fever for five days his postoperative

course was uneventful. 500 cc. of blood was given daily for the first three days. The Wangensteen suction was removed on the third day, he was out of bed on the fourth day and placed on a Muelengracht diet on the sixth day. The skin and tension sutures were removed on the ninth and twelfth days and he was dismissed from the hospital on the fourteenth day. Before dismissal his hemoglobin was 94 per cent.

He returned to work as a baker on the twenty-ninth postoperative day and since surgery has eaten all types of food without pain.

SUMMARY

1. A report of three patients in the same family, the father, a son and a daughter, with duodenal ulcer confirmed by operation is presented. The remaining members of the family consist of: (a) the mother who has never had symptoms referable to the gastrointestinal tract, (b) a son who has a chronic duodenal ulcer roentgenologically and (c) a daughter whose gastrointestinal series revealed "duodenal irritation."

2. A review of the literature to discover similar cases proved confusing because of the indiscriminate use of terminology and the inexact methods of diagnosis.

3. The majority of authors favor the theory that it is likely that a hereditary predisposition is one of the main factors in the production of duodenal ulcer.

4. It is hoped that this report will stimulate others to report similar patients so that more definite conclusions concerning the role of heredity in the etiology of duodenal ulcer may be drawn.

BIBLIOGRAPHY

1. Eusterman, G. B., and Balfour, D. C.: The Stomach and Duodenum, Phila., W. B. Saunders Co., 1935, pp. 262-263.

2. Hurst, A. F., and Stewart, M. J.: Gastric and Duodenal Ulcer, Great Britain, Oxford Univ. Press, 1929, pp. 37-40, pp. 456-458.

3. Riecker, H. H.: The Familial Incidence of Peptic Ulcer. Ann. Int. Med., 7:732-737, December, 1933.

4. Huddy, G. P. B.: A Study of the Family Histories of 300 Patients Suffering from Chronic Upper Abdominal Lesions. Lancet, 2:276-278, August 8, 1925.

5. Wilkie, D. P. D.: Duodenal Ulcer in the Female. Lancet, 2:1228-1231, December 10, 1927.

6. Kanevsky, J.: The Constitutional Aspects of Peptic Ulcer. Am. J. Med. Sc., 206:90-112, July, 1943.

7. Hunt, T.: Chronic Peptic Ulcer. Practitioner, 138:139-150, February, 1937.

8. Willcox, P. H.: Gastric Disorders in the Services. Brit. Med. J., 1:1008-1012, June 22, 1940.

9. Smith, D.: A Statistical Review of Gastric and Duodenal Ulcer. Brit. Med. J., 2:293-297, August 8, 1928.

10. Held, I. W., and Goldbloom, A. A.: Pathogenesis of Peptic Ulcer. M. Clin. N. Amer., 14:319-364, September, 1940.

11. Lindlau, N.: Zur Frage der Erblichkeit des Ulcus duodeni and ventriculi. Muchener Medizinische Wochenschrift, 87:1356-1360, December 6, 1940.

12. Bockus, H. L.: Gastro-Enterology, Philadelphia, W. B. Saunders Co. 1943. Vol. 1, pp. 331-332.

TORULA INFECTION OF THE CENTRAL NERVOUS SYSTEM

Report of Two Cases With a Brief Review of the Literature

EDWARD WASSERMAN, M.D., *Bridgeport*

The Author. *Formerly Resident, Fifth and Sixth Medical Services (Boston University) of the Boston City Hospital; now practicing Internal Medicine in Bridgeport*

IN 1894, Busse isolated from a fatal case, with multiple lesions of skin and viscera, a yeastlike organism which was later identified as *Cryptococcus neoformans (Torula histolytica)*.[32] This disease is called "blastomycosis" in the European literature and "European blastomycosis" in America to distinguish it from "American blastomycosis" which is caused by another organism. This report deals with two cases of central nervous system infection with *Torula histolytica*. No attempt has been made to review the literature completely.

CASE 1

A 50 year old white shoemaker was admitted to the Boston City Hospital because of severe headaches with drowsiness, progressively increasing confusion, and restlessness of several months duration.

For four months prior to admission he had repeated upper respiratory infections associated with easy fatigability, anorexia, and severe left frontal headaches. One month before entry he was hospitalized elsewhere with a tempera-

From the Fifth and Sixth Medical Services (Boston University) of the Boston City Hospital

ture of 101° and received treatment for left frontal, maxillary, and ethmoidal sinusitis. After a week he seemed improved and returned home. He remained confined to bed, however, because of severe headaches which appeared two to three times daily and lasted for an hour or more. One week before admission he had several episodes of vomiting. He appeared very dazed and drowsy four days before entry, but was unable to sleep because of the headaches which gradually increased in severity and frequency. He became irrational and confused two days prior to admission, necessitating restraints. His speech was unintelligible to his family and he was entirely oblivious to his surroundings.

Past history was noncontributory. The family history was significant in that one son had recently been found to have pulmonary tuberculosis.

On admission, the patient, who was well developed and well nourished, was delirious, confused and disoriented in all spheres. Temperature was 102°, pulse 110, respirations 28 per minute, and blood pressure 130/100. Speech was confined to unintelligible shrieking and there was constant hyperkinesis following no purposeful pattern. There was a moderate degree of nuchal rigidity and frequent grotesque facial grimacing. Left facial and left arm weakness were noted and all reflexes were absent. Ophthalmoscopic examination revealed 1-2 diopters swelling of the right disc with several hemorrhages at the disc margin. Remainder of the physical examination was not remarkable. Laboratory data showed the white blood cell count to vary between 10,000 and 18,000. Urinalysis was normal as were the blood chemistry values.

At the time of admission it was thought that the patient represented a surgical emergency, and a bilateral exploration for frontal abscess was performed without revealing localized accumulation of purulent material. Lumbar puncture just prior to operation showed an initial pressure of 500 mm. of water, the fluid was slightly turbid and contained 250 lymphocytes and 800 red blood cells. After operation, because the spinal fluid protein was 126 mg. per cent, sugar 19 mg. per cent, and the chlorides 672 mg. per cent, a tentative diagnosis of tuberculous meningitis was made. Encephalitis of unknown etiology was also considered likely. On the 14th hospital day it was noted that the so-called lymphocytes were atypical with some budding. Sabouraud's medium yielded positive cultures for Cryptococcus neoformans. Successive lumbar punctures revealed similar bacteriological and chemical findings.

His course was that of chronic meningitis with gradual subsidence of temperature and slight clinical improvement, but his mental condition remained clouded. Sulfapyridine therapy seemed to have no effect. Because of his deteriorated mental status and the incomplete clinical recovery, he was transferred to a nursing home two months after admission.

CASE 2

A 52 year old white mechanic was admitted to the Boston City Hospital in a semicomatose state. Five days prior to admission he became delirious and became he was a known chronic alcoholic, this was considered to be an episode of delirium tremens. He became progressively more stuporous during the next few days and was treated with both penicillin and sulfadiazine without effect. Past history revealed that he had experienced a similar episode four months before the present admission which had apparently responded to large doses of penicillin.

On admission he appeared very toxic and seriously ill. He was semicomatose, but could be aroused by noxious stimuli. Temperature was 103°, pulse 120, respiratory rate 32 per minute and blood pressure 150/70. A moderate degree of nuchal rigidity and a 2 diopter papilledema of the right disc were noted. Neurological examination revealed generally hypoactive reflexes and positive Kernig's signs.

Laboratory data showed a white blood cell count varying from 5,300 to 12,000. Blood chemistry values were normal. Lumbar puncture revealed an initial pressure of 320 mm. of water, and a turbid fluid containing 20 lymphocytes, 100 polys, and 490 red blood cells. The total protein was 182 mg. per cent, chlorides 649 mg. per cent, and sugar was reported as being too low to read. These values were all very similar to those found on lumbar puncture during his admission four months previously.

Brain abscess was tentatively diagnosed and intravenous aureomycin therapy was started in addition to large intramuscular doses of penicillin. Seven days after admission the initial spinal fluid culture yielded Cryptococcus neoformans on Sabouraud's medium, and India-ink preparations revealed numerous yeast cells with a clear halo. Spinal fluid removed on subsequent days also produced this organism. At this time large doses of sulfadiazine were also administered. His coma progressively deepened, the temperature remained elevated, and he expired after nine days of hospitalization.

DISCUSSION

Cryptococcosis is a systemic fungus infection caused by the Cryptococcus neoformans, a yeastlike organism also called Torula histolytica. The infection shows a predilection for the central nervous system, but may also involve the lungs,[1,2] skin,[3] nasopharyngeal structures,[4] lymph nodes,[5,6] and muscles and bones.[7,8]

In infected materials such as sputum, spinal fluid, and pus, this organism occurs as small, round to oval, budding cells with refractile capsules which average about 10 microns in diameter.[9] The capsule is seen easily in fresh preparations of pus if examined under reduced light. The material may be mixed with India ink and microscopically the fungus is seen as a small, oval cell in the middle of a larger colorless area, the capsule, which is surrounded by the black particles of ink. Capsules may also be observed in stained sections of tissue.[10] This organism grows readily on Sabouraud's medium at both room temperature and 37° C; the colonies appearing within 1 to 3 weeks. Inoculation of mice or rats demonstrates the pathogenicity of the fungus. It has not been determined whether torulosis is an endogenous or exogenous infection.

In most instances, the respiratory tract has been considered the route by which the fungus enters the body. It has been reported as gaining entrance by way of the gastrointestinal tract,[11] tonsils,[12] and other portals. Naturally occurring infections in animals are recorded[13] but there is no evidence that the disease has been transmitted from animal to man or from man to man. Cryptococci have been isolated from the surfaces and juices of certain fruits and from the feces and skin of normal individuals.[14]

The disease has been described in all races and from all parts of the world.[15,16] There appears to be a predilection for males[17] and its occurrence in the newborn has been described.[18]

Infections of the skin and subcutaneous tissues are not characteristic, and the lesions may be those of pustules or may simulate myxomatous tumors.[9] Pulmonary infections may be symptomless and discovered only by sputum examination after a lesion has been noted on routine chest x-ray. However, low grade fever and cough may be noted.

Involvement of the central nervous system is by far the most common type of infection with this organism. This may occur as a meningoencephalitis alone or may be part of a generalized infection.[19,20,21,22] A pathological classification of central nervous system torulosis was made by Freeman,[23] including a purely meningeal form, a perivascular form with small granulomas in the cortex, and an embolic form with deeply placed lesions lying chiefly in the gray matter. The meningeal systems are those of chronic meningitis, which usually begin insidiously with intermittent headaches which later become more severe and continuous. Nuchal rigidity and all other signs of meningeal irritation develop as the infection progresses. Other findings include papilledema, diplopia, nystagmus, and paralyses. Although the eventual outcome of the disease is practically always death, there is a great variance in the severity and length of the clinical course between onset of initial symptoms and exitus. Occasional periods of remission have been noted. One to six months has been the usually recorded duration of the disease. One case survived almost eight years after onset.[24] Occasionally a focal collection of cryptococci may simulate a brain tumor and localizing signs may predominate.[25] The disease may also be confused with brain abscess, subarachnoid hemorrhage, subdural hematoma, encephalitis, and meningitis of pyogenic, luetic, tuberculous or virus origin.[26]

In torula meningitis the spinal fluid usually shows increased pressure and pleocytosis, with counts ranging from 100 to 800 cells per cc.[9] The predominating cell is the lymphocyte. One cause for mistaken diagnosis is failure to recognize the cryptococci which are frequently confused with lymphocytes or red cells. The finding of budding forms should immediately indicate the proper diagnosis. A single negative culture does not rule out the possibility of central nervous system torulosis because occasionally in well authenticated cases a negative culture was obtained interposed between a number of positive ones.[6] Knowledge of this fact should be kept in mind in evaluating therapy. The spinal fluid is usually opalescent, slightly yellow, with an elevated protein. The sugar is significantly diminished and the chlorides may be likewise. The peripheral white blood cell count is usually normal, although there may be a leukocytosis. There are no reliable serologic or skin tests.

The prognosis of torula meningitis is very poor, and most patients succumb within six months after the beginning of symptoms.

Treatment of this disease is unsatisfactory. Recovery following treatment with sulfadiazine[27] has not been confirmed by subsequent observers.[28] Animal experiments showed no beneficial effect of the administration of sulfadiazine, postassium iodide or combinations of the two drugs.[29] Penicillin has also produced a similar lack of effect.[30] Clinical trial of streptomycin is justified since suggestive evidence of its value has been obtained in animal experiments.[31]

The two cases reported in this paper illustrate most of the points discussed above. Correct etiology in both cases was unsuspected until positive spinal fluid cultures for the organism were obtained. In case No. 1, the patient underwent surgery for a suspected frontal lobe abscess before the correct diagnosis was determined. A brain abscess was also considered likely in case No. 2 before cultures produced growth, thereby revealing the true etiology. In the first patient, it is likely that the initial manifestations of his disease began four months before admission with the onset of repeated upper respiratory infections and systemic symptoms. In this connection, it is noted that the second patient had been hospitalized four months previously with similar, but less severe, clinical and spinal fluid findings. Since the disease is of a chronic nature and temporary remissions are known to occur, the interval

between his two hospital admissions may have represented a remission.

SUMMARY

1. Two cases of central nervous system infection with Cryptococcus neoformans (Torula histolytica) are reported. Both cases were tentatively diagnosed as brain abscess, one patient undergoing surgical exploration, until spinal fluid cultures produced the etiological agent. Despite treatment with sulfa drugs and antibiotics, one case terminated fatally and the other patient progressed to a state of chronic mental deterioration and incomplete clinical recovery.

2. The literature is partially reviewed and the clinical picture and methods of diagnosis are discussed.

BIBLIOGRAPHY

1. Hamilton, J. B., and Tyler, G. R.: Pulmonary Torulosis. Radiology, 47:149, 1946.

2. Haraway, R. M., and Crawford, P. M.: Pulmonary Torulosis: Report of a Case. Ann. Int. Med., 9:334, 1935.

3. Wile, U. J.: Cutaneous Torulosis. Arch. Dermat. and Syph., 31:58, 1935.

4. Jones, E. L.: Torula Infection of the Nasopharynx. South. M. J., 20:120, 1927.

5. Fitchett, M. S., and Weidman, F. D.: Generalized Torulosis Associated with Hodgkin's Disease. Arch. Path., 18:225, 1934.

6. Gendel, B. R., et al.: Cryptococcosis. Am. J. Med., 9:343, 1950.

7. Brewer, G. E., and Wood, F. C.: Blastomycosis of the Spine. Ann. Surg., 48:889, 1908.

8. Jesse, C. H.: Cryptococcus neoformans Infection of Bone: Report of Case. J. Bone and Joint Surg., 29:810, 1947.

9. Harrison, T. R.: Principles of Internal Medicine. Philadelphia, Blakiston Co., p. 944, 1950.

10. Kolmer, J. A., and Boerner, F.: Approved Laboratory Technic. New York, D. Appleton-Century Co., 4th ed., p. 547, 1945.

11. Allen, V. K., and Lowbeer, T.: Rectal Ulcers with Perirectal Fistula as Port of Entrance for Torula Encephalitis. South. M. J., 38:565, 1945.

12. Freeman, W., and Weidman, F. D.: Cystic Blastomycosis of the Cerebral Gray Matter caused by Torula histolytica. Arch. Neurol. and Psychiat., 9:589, 1923.

13. Weidman, F. D., and Ratcliffe, H. L. Extensive Generalized Torulosis in a Cheetah. Arch. Path., 18:362, 1934.

14. Benham, R. W.: Cryptococci, Their Identification by Morphology and by Serology. J. Infect. Dis., 57:255, 1935.

15. Gray, F. C.: Two Cases of Torula Meningitis with Special Reference to Laboratory Findings. South African M. J., 14:2, 1940.

16. Hooper, K. H.: Torulosis in Queensland. M. J. Australia, 2:669, 1941.

17. Voyles, G. Q., and Beck, E. M.: Systemic Infection Due to Torula histolytica. Arch. Int. Med., 77:504, 1946.

18. Neuhauser, E. B. D., and Tucker, A.: The Roentgen Findings Produced by Diffuse Torulosis in the Newborn. Am. J. Roentgenol., 59:805, 1948.

19. Greening, R. R., and Menville, L. J.: Roentgen Findings in Torulosis. Radiology, 48:381, 1947.

20. Ratcliffe, H. E., and Cook, W. R.: Cryptococcosis. U. S. Armed Forces M. J., 1:957, 1950.

21. Magarey, F. R., and Denton, P. H.: Torula histolytica Infection of the Central Nervous System. Brit. Med. J., 1:1082, 1948.

22. Burger, R. E., and Morton, E. B.: Torula Infection: A Review and Report of Four Cases. Surgery, 15:312, 1944.

23. Freeman, W.: Torula Meningo-Encephalitis: Comparative Pathology in Nineteen Cases. Tr. Am. Neurol. Assoc., 56:203, 1930.

24. Reeves, D. L.: Torula Infection of the Lungs and Central Nervous System; Report of Six Cases with Three Autopsies. Arch. Int. Med., 68:57, 1941.

25. Swanson, H. S., and Smith, W. A.: Torula Granuloma Simulating Cerebral Tumor. Arch. Neurol. and Psychiat., 51:426, 1944.

26. Mosberg, W. H., Jr., and Arnold, J. G., Jr.: Torulosis of the Central Nervous System. Ann. Int. Med., 32:1153, 1950.

27. Marshall, M., and Teed, R. W.: Torula histolytica Meningoencephalitis, Recovery Following Bilateral Mastoidectomy and Sulfonamide Therapy. J. A. M. A., 120:527, 1942.

28. Goldberg, F. A.: Torula Meningitis. Memphis M. J., 23:129, 1948.

29. Beck, E. M., and Boyles, G. Q.: Systemic Infection due to torula histolytical: Effect of Chemotherapeutic Agents in Experimentally Produced Infection. Arch. Int. Med., 77:516, 1946.

30. Jones, S. H., and Klinch, G. H.: Torula Histolytica Meningitis: Case Report and Therapeutic Experiments. Ann. Int. Med., 22:736, 1945.

31. Beck, E. M., and Muntz, H. H.: Experimental Therapy of Generalized Torulosis in Rats with Streptomycin. J. Lab. and Clin. Med., 33:1159, 1948.

32. Busse, O.: Ueber Saccharomyosis Hominis. Virchow's Arch. f. path. Anat., 140:23, 1895.

ADRENOCORTICAL EXTRACT IN PEDIATRICS; ITS POSSIBLE USE IN ATELECTASIS OF THE NEWBORN

R. William Provenzano, M.D., *Cambridge, Massachusetts*

Although the exact relation of atelectasis to neonatal mortality is not entirely clear, it is a major factor responsible for death in the newborn infant. The frequent occurrence of massive atelectasis in babies delivered by cesarean section and in premature infants is impressive. This symptomatic state may be primary or may develop secondary to other debilitating conditions. Because shocklike symptoms in a patient with adrenocortical hypoplasia were relieved by cortical extract,*[1] and because the hormonal extract produced a more rapid clearing and aeration of the lung fields in the newborn,[2] it was believed that deficiency of the infants' cortical hormones might be a predisposing factor precipitating or producing atelectasis. Studies of eosinophil response in the premature normal, and atelectatic infants after the use of epinephrine and adrenocortical extract suggests that shortly after birth adrenal activity is diminished. This is in conformity with work of Klein and Hanson,[3] and Sutton and Lee.[4] In this study it is our purpose to establish the possible clinical value of ACE in atelectasis. The results of eosinophil response of premature and normal infants, and infants delivered by cesarean section and those showing atelectasis are reported.

All patients in this study showed evidence of anoxia. The patients were placed in a highly humidified, constantly oxygenated incubator. An Isolette unit was preferred, but many patients were placed in an Armstrong unit within which a vaponebulizer was used to increase the humidity. Infants delivered by cesarean section had gastric suction at birth and repeated in one hour. Vitamin C in three doses of 100 mgms. were given separately, but at the time of administration of adrenocortical extract. (Combined use of vitamin C and ACE caused severe subcutaneous reaction in four patients.) Each infant who received the ACE was given 2 cc. to start and this was repeated in two and four hours. It was then continued in either 1 cc. or 2 cc. dosages every four hours until the response was considered adequate as determined by a symptom free state. The dosage used was arbitrarily chosen, and the maintenance dose of 1 cc. was used if infant weighed less than five pounds, otherwise the 2 cc. dosage was used. A vitamin K analog was also given shortly after birth. Penicillin in daily dosages was used prophylactically. The fluid intake was maintained either by intravenous or subcutaneous route, nothing being given orally until the respirations were normal.

During the course of this study, epinephrine-eosinophil tests[5] and adrenocortical extract-eosinophil response were studied in several patients. The number of cases in which these determinations were performed are few. The results obtained thus are not conclusive, but they do suggest that in the immediate postnatal period there is diminished adrenal activity. The results are summarized in the accompanying chart.

Of the 72 patients with anoxemia, the causes of which are summarized in a previous publication,[2] there were 27 patients with atelectasis diagnosed clinically and confirmed by x-ray. Nine of the 27 patients who received the adrenal extract showed improvement within 12 hours. Nineteen patients became asymptomatic within 24 hours. There were eight patients who showed no improvement within 24 hours, one of these became asymptomatic within 48 hours, and four within 72 hours. There were three deaths in this group. In the control group four patients showed improvement within 8-12 hours and a total of seven patients were asymptomatic within 12-24 hours. Twenty patients revealed no apparent improvement up to 24 hours, but four showed sud-

*The extract used in this study was supplied by the Upjohn Company, through the courtesy of H. F. Hailman, M.D., Medical Division.

Adrenocortical extract (ACE), a biologically standardized extract is prepared from adrenal glands containing the cortical activity that is essential for life. Each cubic centimeter contains not less than 50 dog units or 2.5 rat units.

From the Pediatric Service, Cambridge City Hospital, Cambridge, Mass., and St. Elizabeth's Hospital, Brighton, Mass.

Chart I

Summary—Results of Epinephrine—ACE Eosinophil Response

Type of Patients	No. of Cases	Average Initial Eosinophil Count	Per Cent Depression Epinephrine	Per Cent Depression ACE	Average Age in Hours	Remarks
Premature	9	352/mm	28.4		1-40°	(1) 2 cc. ACE used (2) Tests performed 4-6 hours later (3) Epinephrine 1:1000 solution 0.1 cc. was used in all, but prematures 0.05 cc. was used
	9			42.1		
Normal	9	319/mm	34.3		1-12°	(1) Four of these showed 42.1 per cent response with epinephrine (2) Total range of eosinophil were 67 to 1018
	9			47.1		
Infants delivered by cesarean section	4	323/mm	39.1		1-12°	After twelve hours average eosinophil of 347 with response of 32.6 per cent was obtained
	4			45.3		
Atelectatic Infants	3	389/mm	29.8		1-24°	Prior to signs of atelectasis no determinations were performed. Four of these patients first showed signs of atelectasis 6-8 hours after birth
	3			44.6		

den improvement within 24-48 hours, and seven became asymptomatic between 48-72 hours postnatally. There were nine deaths in this group.

Many patients responding to the use of the extract showed signs of improvement within 24 hours. The response seemed to be in relation to the time of administration; the earlier the extract was given, the more effective it seemed to be with the first signs of improvement occurring within 8-12 hours after the initial dose of the drug. The improvement which was noted was referable to the respiratory and muscular systems. There was increased muscular tone and activity. Cyanosis diminished with the cry becoming less feeble and clinical moisture in the lung fields being largely absorbed with full aeration occurring. The patients who showed improvement without the use of ACE presented similar changes which occurred 48 to 72 hours postnatally. As compared with those receiving the hormone, the listlessness, dyspnea, retraction, generalized weakness and duskiness or cyanosis continued over a much longer period.

Discussion

Shortly after birth, newborn infants, infants dedelivered by cesarean section and premature infants reveal an adequate response to adrenocortical extract. This is shown by a satisfactory depression of circulating eosinophil when adrenal extract is administered. The poor response obtained in a similar group of infants when given epinephrine suggests that there is an insufficient amount of adrenocortical hormone. This deficiency may be due to the infants inability to elaborate an additional amount of hormone as revealed by the satisfactory eosinophil response on replacement therapy.

The newborn infant when exposed to an additional stress and strain of postnatal readjustment, such is is caused by anoxia and prematurity, may demand an increased supply of esential adrenocortical hormones. The adrenal cortex of the newborn may not be able to supply such additional hormone. This postnatal period of adrenocortical hormone deficiency may be a factor predisposing the newborn infant to respiratory complications and shock. Although the exact physiological mechanism of function must be further studied the beneficial results obtained in patients with atelectasis and in prematures may be explained on the basis of replacement therapy during this temporary period of adrenal cortical deficiency.

Summary

The results of epinephrine-eosinophil and adrenocortical extract eosinophil response in the immediate postnatal period in the normal, prematures, cesarean section and atelectatic infants are recorded. There is evidence that there is diminished activity of adrenal cortex in the newborn in the immediate postnatal period.

The results of the use of ACE in patients with atelectasis are presented. That a deficiency of adrenocortical hormone may be a predisposing

cause for precipitating or producing atelectasis is mentioned. The beneficial results of the use of the hormone in these patients are discussed.

I am indebted to C. De Feo, R.N. and Sister St. Claire, R.N. for their cooperation in compiling statistical data. I wish to thank R. Schulz, M.D. and J. Graham, M.D. who performed the eosinophil counts, also Philip McGovern, M.D. and Peter Weiss, M.D. for the courtesy of including their private patients in this study.

REFERENCES

1. Provenzano, R. W.: Adrenocortical Hypoplasia in the Newborn Infant. N. E. J. Med. 242:87-89, 1950.

2. Provenzano, R. W., McGovern, P., Schulz, R., Hester, J.: Adrenal Cortex Extract in Pediatrics, (Possible effect on the Respiratory System of the Newborn). Am. J. D. of Child. 81:323-328, 1951.

3. Klein, R., and Hanson, J.: Adrenocortical Function in the Newborn Infant as Measured by Adrenocorticotrophic Hormone-eosinophil Response. Ped. 6:192-196, 1950.

4. White, F. P., and Sutton, L. E., Jr.: Observations on Pituitary-Adrenal Response to Epinephrine. Ped. 5:876-882, 1950.

5. Thorn, G. W., Forsham, P. H., Prunty, F. T. G., and Hills, A G.: Test for Adrenal Cortical Insufficiency. J. A. M. A. 137:1005, 1948.

THE NARCOTICS PROBLEM IN CONNECTICUT

Daniel P. Griffin, M.D., *Bridgeport*

A number of factors have conspired to focus recent attention on the problem presented by the abuse of habit-forming drugs. In some cases, e.g., marihuana and heroin, any use may be considered unwarranted. Marihuana has no ethical application in medicine and heroin has long since been outlawed as an unnecessary and disproportionately dangerous drug.

It may be worth noting that these two preparations are now receiving special attention. Despite the vigorous and intensive efforts of Treasury officials, it appears that large quantities of both are generally available in a number of our larger cities. Further, it is significant that they are widely used by drug peddlers to corrupt the young and thus enslave additional victims. The common practice is to initiate the candidate with marihuana. Once he is interested, it is usually a simple matter to teach him the use of heroin.

While marihuana is not considered a narcotic drug in the sense that that term is ordinarily used, it is properly put under the same control as the products of opium and cocoa leaves. More recently, State laws have been enacted to supervise the sale of barbiturates. These drugs are sedatives, or hypnotics, rather than narcotics, but there is mounting evidence of their dangerous properties when they are employed without scientific direction.

It is, I believe, quite unnecessary to review the history of drug addiction so far as it is known to us, or to discuss the means for smuggling or otherwise outwitting the law in the sale of these dangerous products. The history of addiction is academically interesting, but it has no practical bearing on the subject of our inquiry and while it is generally admitted that there is considerable illicit traffic in drugs, the detection and punishment of such offenses lies largely in other and generally competent hands.

Neither do I think any constructive purpose would be served by a detailed review of the various symptoms associated with the misuse of these various drugs. Such information is the common property of physicians everywhere and not many others need to be familiarized with it. Much the same comment applies to the disturbing and sometimes serious symptoms which develop during the withdrawal period and, of course, no physician of experience needs to be reminded that withdrawal is not synonymous with cure.

With these tempting topics of discussion disposed of, we may now consider more specifically how much of a problem addiction to narcotics appears to present in Connecticut. Admittedly, even approximate accuracy is not to be expected, nor is it essential. Victims of addiction from other States come to Connecticut sanitaria for treatment and, no doubt,

From a report to the Committee on Mental Health, Connecticut State Medical Society

there is a similar movement in the opposite direction. Nevertheless, available statistics give us some reason for believing that the situation in Connecticut is relatively favorable. The number of patients treated each year in our State hospitals and private sanitaria is relatively small. To determine this, the following letter was sent to the head of each of these institutions in which such patients are treated. (Drug addicts are not received at Stamford Hall or Silver Hill. Indeed, they are not very welcome at any Connecticut institution.)

"Dear Doctor Doe:

"I am a member of the Committee on Mental Health of the Connecticut State Medical Society. I have recently been assigned to the task of studying the narcotics problem as it may exist in Connecticut and I am now assembling such data as is available on this subject.

"If it represents a problem of any significance in your patient population, I will be most appreciative of your comments on its extent and perhaps some remarks about what you have found to be the most effective methods of treatment. Any additional views on the subject which you may care to offer will be greatly appreciated.

"We are trying to determine whether Connecticut has such a problem and, if so, what are its dimensions."

Replies were received from each doctor addressed. One reported a single case of demerol addiction, another two cases of barbiturate habituation. (None of these patients was a resident of Connecticut.) The largest number treated at any institution in the past twelve months was four. In general, these reports correspond with your reporter's experience during the time he was engaged in mental hospital administration.

So far as may be judged from the first chapter of our inquiry, addiction to narcotics in the State of Connecticut would appear to be at a minimum.

THERAPY

Not all of the replies made any detailed reference to therapy. With those that did, there was a fairly general agreement on the following principles. (These were not specifically catalogued, but I have included a cross section of the comments made by various correspondents.)

(1) Institutional care for a period of four months with gradual withdrawal of the drug is favored. Naturally, suitable precautions are taken to prevent concealment of drugs by the patient or the introduction of a fresh supply by a confederate. The rate of withdrawal varies—seven to fourteen days may be considered as average.

(2) Suitable drug therapy, as well as physical measures, are employed to control in some measure the distressing symptomatology which accompanies withdrawal. Sedative and hypnotic drugs, analgesics, subcoma doses of insulin, all have a limited field of usefulness. Cortisone has recently been employed, but none of my correspondents referred to it. In many instances, the patient requires substantial physical, as well as emotional, support during this trying period.

REHABILITATION

This embraces the whole range of positive therapeutic influences which may be brought to bear on the particular case. It includes occupational, physical and perhaps drug therapy. It includes the development of external interests, hobbies, avocations and possibly a new field of life work. It includes an adjustment of the business or domestic situation, or the correction of economic maladjustments. Particularly, it includes a course of individual psychotherapy based on the patient's particular handicaps and essential needs.

PROGNOSIS

Statistically, this is not very encouraging. One correspondent writes:

"As you know, most of the drug addictions are associated with the kinds of character disorder in which there is very little regard for a meaningful relationship with another person and where there is very little internalized self discipline. Successful treatment expectancy is not much more than 20 per cent of all such cases. This pessimistic evaluation does not, of course, apply to the adolescent narcotic user if he is treated soon after the discovery of his addiction."

Some years ago, a good deal was said about the employment of substitutes manufactured synthetically to replace morphia. It does not appear that these have justified the optimistic comments originally made about them and it is conceded that they are quite as capable of developing addiction as the drugs they were intended to replace.

MEDICOLEGAL ASPECTS

On the legal side of the question, the Connecticut figures are reassuring. Arrests for violation of the

antinarcotics laws in 1950 were 18, with 7 additional for the possession or sale of marihuana. Comparable figures from other States were:

Violations reported from:	NARCOTICS	MARIHUANA
Alabama	31	9
Arizona	35	34
California	390	108
New York	572	85
New Hampshire	1	0
Nevada	43	3
Oklahoma	130	31

Through the courtesy of Mr. Edward A. Murphy, Federal narcotics agent in New Haven, I was put in contact with Mr. George H. White, the district supervisor at the Boston office. In reply to my question about the probable number of persons in Connecticut in whom his Bureau would be interested, Mr. White states:

"I would prefer to avoid attempting any realistic estimate of the number of persons using narcotic drugs in one form or another, and direct my attention to the bald fact that many persons of various ages are using drugs and must be dealt with."

A second question directed to Mr. White was this one: "Investigations in other cities have frequently resulted in the complaint that enforcement is inadequate because of lack of efficient personnel. Do you feel that the problem of illicit use of drugs in Connecticut is now under adequate control or do you share the view expressed elsewhere in the country, that a larger staff is needed?" Mr. White replied:

"This Bureau does not seek a vast expansion of its personnel, but we do constantly encourage municipal, county and State authorities to create specialized narcotic law enforcement agencies of their own and assume such enforcement responsibility as a local problem. At present less than five States have such enforcement machinery and but a few cities have a practical Narcotic Division within their police department. As narcotic law enforcement is highly specialized, the combining of this function with miscellaneous police work is always unsatisfactory. . . . As to whether the use of illicit drugs in Connecticut is now under 'adequate control,' I would hesitate to say that it was as long as there is admittedly an addict population of any size whatsoever in your State."

My third question related to the existence and extent (if it did exist) of teen-age addiction in Connecticut. Mr. White says:

"With regard to 'teen-age' addiction, I do not feel it can be said authoritatively that this situation does not exist in Connecticut. Certainly, however, few, if any, cases have come to our attention. Again, I must remark on the ambiguous nature of the word 'addict' as so loosely used in newspaper accounts and otherwise throughout the country. There may well be numerous instances of minor children who occasionally smoke marihuana which have not come to our attention. Our experience has shown such occasional use of marihuana frequently develops into the full time use of heroin. Herein lies a great potential danger to the community. Obviously, our one Connecticut officer cannot be expected to 'police' the Connecticut population in this respect, but trained local police authorities could do much to suppress this phase of delinquency."

My fourth question was, "May I assume that you share Commissioner Anslinger's views on the dangers of lecturing to groups of teen-agers on the problem of addiction? Is there anything that can safely be done in the way of education that will help to protect this group? Should this counsel be given exclusively in the home, as is now being suggested for sex education?" To this, Mr. White replied as follows:

"Commissioner Harry J. Anslinger's views on the danger of lecturing to groups of minors on addiction represent the consensus of opinion of such organizations as the United Nations Economic and Social Council, the American Medical Association and the Women's Christian Temperance Union. As resolved by the United Nations group, the only exception to this would be such education in countries where the use of opiates is so widespread as to become part of the general culture, as in India, Iran, Indo-China, etc. A graphic example demonstrating (that) knowledge of an evil does not prevent its practice is found in the case of physicians, whose incidence of addiction to narcotic drugs is higher than that of any other noncriminal category. There, it is the availability of the drug which brings about this high percentage of addiction even though a physician, of all persons, has the greatest knowledge of the penalties of abuse.

"I am enclosing a bulletin of the American Town Meeting of the Air which includes a radio program transcript which may be informative in this regard."

A fifth question was presented in this fashion: "I enclose a couple of clippings from the *Herald-Tribune*. I will be glad to have your views on

Director Harrison's suggested program; particularly, I would like to know whether you agree with him that we are too likely to place 'a comfortable reliance on harsh laws.' I think this is important since there is a growing tendency to provide stiffer penalties for violations." A part of Mr. White's reply follows:

"Dr. Harrison, director of the Bureau of Public Affairs of the Community Service Society of New York, has many constructive suggestions in the *New York Tribune* article you enclosed. 'Harsh' laws by themselves will not solve our problem, but a more realistic appreciation of the gravity of the crime by legislators and judges will, without question, relieve the situation. The harsh 'Lindbergh law' providing life imprisonment for kidnapping certainly had an immediate effect in reducing that crime to a minimum. The deliberate sale of habit-forming drugs to a minor is just as heinous, although the effects thereof are not immediately so apparent.

"A striking contrast is found in the narcotic situation in the adjoining Boroughs of Brooklyn and Manhattan. In Brooklyn, sentences of 10 and more years imprisonment are not uncommon and few street peddlers are found in that community. On the other hand, until recently a sentence in excess of 18 months was rare in the federal courts of Manhattan where the street sale of narcotic drugs is probably more prevalent than anywhere else in the country. Delaware's whipping post seems to have had considerable effect in reducing that State's quota of crime in general. Granted the threat of a severe penalty has never completely prevented any type of crime, it may be considered that the type of community thinking which provides 'harsh' penalties is the same type of community spirit which aggressively rejects public corruption in general and thereby serves notice that antisocial behavior will not be tolerated."

There is attached hereto a bulletin of "America's Town Meeting of the Air" of July 10, 1951, which is mentioned in Mr. White's reply to my fourth question. This refers to the six hundred and seventy-second broadcast; the subject: "How Can We Stop Making Drug Addicts of Our Children?"

Mr. Howard Whitman (author of "Terror in the Streets," etc.) blames the racketeers and peddlers for teen-age addiction. He felt that they took advantage of adolescent enthusiasm and adolescent insecurity in an uncertain world, to build up a profitable market for their products. He estimated sales at $36,000,000 a year and pictured the drug peddler as pleased with the suggestion that hospitals be built for the treatment of young drug addicts. He felt that this would indicate our surrender to the idea that drug addiction was destined to be one of the standard hazards of growing up. He felt that one solution of the problem would be to triple the usual penalties when drugs are sold to minors.

Mr. George H. White, to whom previous reference has been made in this report, agreed with Mr. Whitman, but felt that more should be said. He emphasized the importance of international control, asserted that narcotic addiction, while a part of the general delinquency problem, required immediate and special attention, but strongly opposed lectures to teenagers as a prophylactic measure. He said, "No one has suggested juvenile training programs to suppress prostitution; there is no more reason for such antinarcotic education." Mr. White emphasized the connection between narcotics and crime and said that most violators of the narcotics regulations had prior criminal records. This includes teenage addicts (32 out of 47 recently studied). He added, "Association with addicts is the principal cause of addiction."

"States and cities must initiate their own immediate enforcement and quarantine measures to eliminate these sources of infection. I feel we should be more concerned with 'curing' delinquents and addicts yet unborn and attempt to remove from society those factors which, otherwise, sixteen years from now, will lead those youths into the same evil ways.

"This is not a police problem. It is the responsibility of the community, the schools, the churches and, most of all, the home itself."

Mr. Victor H. Vogel, director of the United States Public Health Service Hospital at Lexington, Kentucky, agreed that law enforcement should be emphasized, but reminded the audience that "the death penalty in China for addicts didn't stop addiction in China." He said, "It takes two things to make an addict. It takes narcotic drugs, and it takes a person who wants to take the drugs." A small minority of the older group especially become accidentally addicted. Many, especially younger addicts, are the victims of group psychopathology. Those who relapse (in either group) are often unstable and inadequate personalities. Prevention is one approach; treatment and rehabilitation is the other. He was opposed to stiff mandatory sentences for all first offenders, though the predatory peddler deserved

such punishment. He favored antinarcotic education. Mr. Whitman agreed with him. Mr. White repeated his objection to exciting the curiosity of small children. There was, however, some emphasis on the difference between proper and improper education. Dr. Vogel felt that lessons should begin in junior high schools and high schools. Mr. White emphasized the influence of the home and community atmosphere. Dr. Vogel felt that some physicians at times prescribed these drugs too freely. Mr. Whitman felt that marihuana, barbiturates and possibly other drugs should engage the attention of federal law-makers. Mr. White felt that publicity was sometimes excessive and might well contribute to creating "an unhealthy situation that didn't otherwise exist." Dr. Vogel, in conclusion, reverted to his emphasis on the value of educational prophylaxis.

Mr. White questioned the statement that there were 25,000 addicts among Chicago's high school children. Dr. Vogel felt also that the astronomical figures sometimes quoted were unreliable. He said, "I'm sure there are many addicts in the large epidemic centers of population that we don't get. But I am inclined to think that if we do just see them in hundreds, the figures are not astronomical in the cities." He added that there had been a slight decline in the number of teenagers admitted to Lexington since February.

In reply to a question, Dr. Vogel favored adequate presentence investigations and perhaps a more intimate acquaintance of the presiding judges with the complexities of the whole situation, so that indeterminate sentences and rehabilitative measures might be widely used in appropriate cases, reserving the stiffer penalties "frequently adequate in existing laws" for those who clearly deserve such punishment. At Lexington it was found that about two-thirds of the patients had no criminal record before they became addicted.

It appears reasonable to conclude that:

(A) The Federal Bureau of Narcotics is doing an exceedingly good job with a small force of men on the local, national and international levels.

(B) Two factors contribute to the development of addiction: (1) The availability of drugs and (2) the personality of the victim.

(C) There is need for community awareness of the character of the problem so that (1) adequate personal counsel can be given in the home with a minimum of risk of exciting dangerous curiosity, and (2) the total situation can be controlled by the enforcement of State laws by adequately trained State narcotics officers.

(D) While there is not general agreement as to whether addiction in most instances begins before a criminal record is established—or vice versa—there is no doubt about the ultimate relationship between addiction and crime. It would be superfluous to offer proof of such an association.

(E) There is also a difference of opinion about the necessity or value, or danger of antinarcotic education. There is some agreement that, if given, it must avoid the stimulation of adolescent curiosity to the point where experiment becomes a temptation.

(F) There is some reason to believe that the size (not the importance) of the problem may have been exaggerated and that we have passed the peak of teen-age addiction. However, continued vigilance is demanded.

(G) While some new laws may be needed to meet special conditions, it is felt that the wise individual application of existing provisions will be adequate to meet most situations. Here, as elsewhere, community spirit is of determining value.

(H) Connecticut appears to be among the more favored States in the catalogue having a low incidence of arrests in proportion to its population. There is no statistical evidence of teen-age addiction, though the possibility that it may exist is admitted.

I would like to express my sincere thanks to Mr. Edward A. Murphy, Federal narcotic agent in New Haven, and Mr. George H. White, district supervisor at the Boston office, for their courteous and valuable aid to me in making this study.

PROFESSIONAL RELATIONS IN MEDICAL CARE INSURANCE

THOMAS J. DANAHER, M.D., *Torrington*

IT IS my opinion that if a medical care plan is a good one; forthright and honest in its dealings with the medical profession, and the medical profession in the area covered is well acquainted with it, that as far as ninety per cent of the physicians are concerned, good professional relations will prevail.

We must realize that there are two problems: One is the professional relations for indemnity subscribers, and the other is the professional relations for service benefit subscribers. In both groups, the fee schedule must be realistic. It must be definitely stated that the fee in the schedule is not what the procedure is worth, but is a fee that people of low income can afford to pay for the services rendered.

For the indemnity group some procedure must be set up to protect subscribers from excessive additional fees. The Connecticut Medical Service has an agreement with the county medical associations, whereby, the subscriber who is of the opinion that he is a victim of an overcharge by his attending physician, is notified that the county medical associations have a professional relations committee that will be willing to consider his problem. The subscriber is given the address of the county society secretary and copies of the letter are sent to the physician involved and also to the secretary of the county society. In this way the subscriber is given the opportunity to request consideration of his problem if he desires.

Plans with service benefits have the problem of defining the eligibility of certain members for service benefits. This should be a matter to be resolved by the physician and the subscriber. Physicians should realize that for patients but slightly over the income levels, they should be guided by the spirit of the plan in deciding whether or not an additional fee should be charged. As far as we can determine in Connecticut, approximately ten per cent of our subscribers in the contract level are treated as service patients.

In most of the contracts in the plans with service benefits, it is required that the subscriber notify the physician "at the time of arrangement for care" that he is in the service benefit class. Here, again, physicians should be guided by the spirit of the plan, realizing full well that many subscribers are emotionally upset when contemplating an operation, and may easily forget to notify the physician of their financial status. Therefore, the physician should make every effort to assist the subscriber and to carefully weigh the circumstances before using this provision of the contract to deny the subscriber service benefits.

In some areas, certain commercial insurance companies have requested that physicians participate with their prepaid medical plan on an equal basis with the nonprofit service and indemnity plan. It must be remembered, that nonprofit service and indemnity plans were organized in order that the majority of the people of the area could insure themselves against certain of the costs of medical care at a price they could afford to pay. When physicians agree to participate in the plans, they are providing professional services at less than the usual fee to persons in certain income brackets, and are also agreeing to prorate their services, therefore, the participating physicians are coinsurers of the enterprises.

In the beginning, in order to get favorable coverage and reduce administrative costs, the subscribers were enrolled in groups. As the present time many plans are covering direct-pay subscribers. If the plans are to attain their goal of insuring all of the people, it can be readily seen that it is necessary to have large groups of employed people enrolled in the plan in order to absorb the poor-risk and the high-administrative-cost subscribers. Otherwise, the cost of the

Summation of a symposium on professional relations in medical care insurance at the Council of New England State Medical Societies, Boston, November 18, 1951

plan for people over sixty-five, people with recurrent illnesses who are no longer employed, and individual direct pay subscribers may be too great.

Commercial insurance companies are confining their coverage to good and average risk to large groups which lend themselves to easy administration, and by so doing they are attempting to take the cream and leave the skim milk for nonprofit medical care plans. The commercial companies who are underwriting individual policies, are doing so with a high premium, with a low net return to the policyholder and with considerable small print in the contract.

For many years, commercial insurance companies in the life and retirement income fields have limited their activities to the good risk and easy administrative groups. Today, in spite of their activity, we have National Social Security, indicating that insurance companies did not meet their social obligations to the people of this country.

If commercial companies are willing to assume the identical obligations of nonprofit service indemnity plans, namely, assume the same risks, have the same premium, have the same fee schedule and have a professional arbitration committee with authority, then the physicians in the area should be willing to consider participating on an equal basis.

Many of our loyal participating physicians today are raising the question of prepayment for diagnostic procedures, especially x-rays. These physicians realize that they are admitting many patients to the hospital as boarders in order to obtain x-rays on the prepaid hospital plan. Our participating physicians have been told many times by different people that as no patient is admitted to the hospital except on the order of a physician, no special services are rendered except on the order of a physician, and that no patient is discharged except on the order of a physician, therefore, the abuse of prepaid hospital plans can only be corrected by physicians.

Physicians realize the above statements are true, however, they are under pressure from patients to admit them to hospitals because prepaid hospital plan contracts cover special services in hospitals, and the subscriber wishes to have these services. Due to the rapid spread of the practice of management paying the premium, the worker is even more insistent that he be admitted to the hospital in order to obtain special services, such as x-ray.

At this time it is very evident that this practice is placing a premium on dishonesty for both the physician and the patient. If the prepaid medical plans are to retain the loyalty of their participating physicians, some steps must be taken at once to provide some diagnostic services, especially x-rays outside of the hospital. This will require some adjustment between interested prepaid medical and prepaid hospital plans, but it can and should be done.

We must always remember that prepaid medical care insurance is primarily for the subscribers. It is voluntary and the success depends upon good service to the individual, and this in turn depends upon the individual physicians in the area served. If the plan is a good one, and the physicians are well acquainted with it, the vast majority of them will cooperate wholeheartedly because they know that the plans benefit their patients.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
BENJAMIN V. WHITE - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

The Medical Education Study Commission

The recently appointed Governor's Commission to study means of enlarging Connecticut's facilities for medical training is of major interest to Connecticut doctors. The two physician-members of the Commission, Dr. Barker and Dr. Hastings, have wide knowledge of the field of medical education and are well acquainted with medical facilities within our State. The Committee, which is composed of seven members, includes one dentist and a former State senator. The Governor's choice of personnel has much to commend it, for this is an affair of all of the citizens and it is their elected representatives who will make final decisions in this important matter.

The Committee will explore all of the medical facilities within our borders and will consider problems concerned in the training of physicians, dentists, nurses, and other medical and dental personnel. More specifically the Committee is asked to consider the capacity of the University of Connecticut to provide for premedical and medical training and the most suitable geographical locations for carrying out such projects. In addition, the Committee will consult with the Connecticut Commission on Intergovernmental Cooperation and other agencies on the possibility of collaboration by our State in regionally financed schools for medical and dental training.

In establishing the Committee Governor Lodge has requested that a report be rendered before the next regular session of the General Assembly, which will be convened in January of 1953, and that the report include recommendations on the type and extent of the facilities needed, on the optimum number of students to be accommodated, on the availability of teaching personnel, and an estimate of the cost which would be involved in constructing such facilities and in their annual operation thereafter. The full Committee includes: Howard E. Houston, Meriden, chairman; Luke Stapleton, Cheshire; Gordon W. Lamont, Darien; Mrs. Arthur Iffland, Torrington; Henry Hicks, D.D.S., Greenwich; Creighton Barker, M.D., New Haven; Louis P. Hastings, M.D., Hartford.

CMS For Physicians

Many physicians have expressed concern about the ethics of the enrollment of physicians for benefits under medical care plans. To some it appears unethical for a physician to accept under any circumstances payments for service rendered to a fellow physician or his immediate family, an idea which has roots deep in antiquity and expressive of a custom in interprofessional relationships of high ideality. There are, however, practical considerations which may tend to modify the circumstances of these relationships. It is common practice for physicians on the receiving end to make gifts or tokens, especially when the attending physician is not a close associate, a practice not always without certain embarrassments. In the case of some specialists in large urban centers it is surmised that no inconsiderable part of a medical practice may be that of physicians or their immediate families. In some instances it has come to attention that under these circumstances a reduced fee is openly charged and embarrassment on both sides thereby avoided.

A recent opinion of the Judicial Council of the AMA has reported that it is not unethical for a physician to accept payment from a prepaid insurance corporation for professional service so rendered to a fellow physician. It would appear that membership in Connecticut Medical Service is an excellent opportunity for doctors to resolve this situation on a mutually satisfactory basis.

The Connecticut Chapter Arthritis and Rheumatism Foundation

The Arthritis and Rheumatism Foundation, a national organization headed by Gene Tunney and the former Air Force Commander in the Pacific, General George C. Kenney, has a Connecticut chapter which will conduct its first statewide fund drive during 1952. The Foundation has a threefold purpose: 1. To help provide improved care for arthitics. 2. To disseminate educational material on arthritis and rheumatism to physicians and the lay public. 3. To provide funds for basic and clinical research in the field.

Forty per cent of the moneys raised by local chapters goes to the national office, which last year spent $250,000 on basic research. During 1951 the Foundation raised $18,000 in Connecticut, chiefly in the Bridgeport area, where an arthritis clinic has been opened under the supervision of Dr. D. B. Hardenbergh and with the active cooperation of nine other physicians. Arthritis clinics also function at the Hartford and the Grace-New Haven Community Hospital.

At the national, state and local levels, the Foundation's programs are established and its funds are allocated only on recommendation of its respective Medical and Scientific Committees, composed entirely of physicians. Dr. Gideon K. de Forest, of New Haven, is National Medical Director of the organization.

The chairman of the Medical and Scientific Committee of the Connecticut chapter is Dr. Joseph J. Lankin of Hartford. Serving with him and Dr. de Forest are Dr. Chester W. Fairlie, Dr. Frieda G. Gray, Dr. D. B. Hardenbergh, Dr. C. N. H. Long, Dr. Dennis S. O'Connor, Dr. Marjorie Patterson, Dr. John R. Paul, Dr. William R. Willard and Dr. George A. Wulp.

Physicians may secure gratis through the Foundation its regular monthly *Bulletin on Rheumatic Diseases*, edited by Dr. Joseph J. Bunim of New York. Also available is a pamphlet, "Home Care in Rheumatoid Arthritis." This pamphlet is for distribution by physicians to their patients. It is not distributed directly to the public. A leaflet, "What You Should Know About Arthritis!" has been approved by the Foundation's national and state Medical and Scientific Committees for public distribution.

Communications concerning the work of the Foundation may be addressed to the Arthritis and Rheumatism Foundation, Connecticut chapter, 211 State Street, Bridgeport 3, Connecticut.

Medical Education in the Present Emergency

In his remarks concerning medical education in the present emergency, Dr. Samuel C. Harvey brings to his thinking a wide experience as a teacher and clinician. His analysis of "group practice" by members of medical school faculties shows deep insight into a situation which has been subject to a considerable misunderstanding based chiefly on the many variations of such practice that now exist throughout this country. He properly points out that the exploitation of such practice by a medical school can hardly occur without the acquiescence and abetting of the faculty itself who of necessity must be competent to operate successfully within such a group.

The question of medical ethics or rules of conduct as applied to physicians employed in any situation other than on an individual fee basis is one which has interested the profession for a long time. The value of such articles of general agreement within the medical profession is not to be questioned for it is by such mutual understanding that the integrity of the profession is maintained. Time, however, has a remarkable way of changing thinking, and men are said to be more like their times than like their fathers. The great number of salaried physicians now in industry, insurance, public health, group and hospital practice, teaching and research, presages opportunities for physicians on an ever widening scale.

When questions involving medical ethics arise they must be resolved with but one viewpoint, the support of the highest things in the tradition of medicine and the upholding of the rights and integrity of the individual. Dr. Harvey's comments in this field of thought and in many phases of present day medical education are presented with penetration and understanding. His paper deserves careful reading.

PROGRESS IN CLINICAL MEDICINE

NONSPECIFIC BENIGN PERICARDITIS

William F. Prestley, M.D., *Hartford*

In 1854 Hodges, quoted by Carmichael et al,[1] described a patient who had acute pericarditis with effusion unassociated with rheumatism whose symptoms disappeared rapidly upon the "judicious application of several blisters to the thorax." Since then, but especially in the past nine years, more and more authors have reported a syndrome which, like primary atypical pneumonia, had either been generally unrecognized previously, or has increased markedly in the recent past, namely, nonspecific benign pericarditis. Barnes and Burchell[2] in 1942 were the first of many[3,4,5] to point out the importance of differentiating nonspecific pericarditis from acute myocardial infarction. The latter diagnosis, with its ominous prognostic implications, if mistakenly applied to the relatively benign nonspecific pericarditis, brings obvious emotional and socioeconomic strain to the patient and his family. For this reason above all others, the characteristics of nonspecific pericarditis deserve wide dissemination among general practitioners and internists.

The etiology of nonspecific pericarditis is unknown but has been assumed since 1906[1] to follow upper respiratory infections. These are presumably of virus origin according to Taubenhaus and Brams[6] who reported dramatic response of the disease to aureomycin. In their series, all bacteriological tests and agglutination tests to virus infections were negative. Tuberculous infection and rheumatic involvement appear to be unlikely etiological agents in view of negative cultures and lack of residual damage, respectively, and in view of the fact that the clinical course of both differs from that of nonspecific pericarditis.

The incidence from published cases is predominantly male. The average age incidence is typically 41[4] as compared with 57 for acute coronary occlusion.[7]

McCord and Taguchi[8] in 1951 reported the autopsy findings of a case of nonspecific pericarditis mistakenly treated as myocardial infarction with anticoagulants. The patient died in shock with an element of cardiac tamponade. Microscopic examination showed "a heavy fibrinous deposit on the visceral pericardium enmeshing many clumps of red cells. A heavy infiltrate of lymphocytes and occasional polymorphonuclear cells was present. There was proliferation of fibroblastic tissue into the fibrin and clotted blood." The myocardium, except for areas directly contiguous to the pericardium, was normal as were the coronary vessels. The pericardial effusion was serosanguinous as is typically found in pericardicenteses[5] in patients with nonspecific pericarditis. The pleura, according to Wolff[3] is uniformly involved and is evidenced clinically by pleural thickening and small effusion. He adds that pulmonary involvement is merely congestion due to compression, and rarely or never is characterized by pulmonary edema.

The clinical picture is then that of a man in his thirties who, two weeks after the onset of an upper respiratory infection, suddenly develops constant substernal aching pain which radiates to the neck, shoulders, anterior chest, and down the medial aspect of both arms. It may, like the pain of coronary thrombosis, radiate to or occur solely in the abdomen.[10] This pain is made worse by motion of the trunk, by swallowing, coughing and deep breathing. It is less severe when the patient leans forward[4] and is much worse on recumbency. With increase of apprehension, a shocklike state which responds to atropine and morphine may be apparent.[5] Typically, according to Barnes,[7] there is no preceding history of hypertension or angina.

The classical signs are those of pericarditis with pericardial effusion: an early fever of 100° to 103° F., a friction rub occurring early simultaneous with the onset of pain and fever and persisting for as long as two weeks, increased cardiac dullness by percussion. The heart sounds may be distant or not.[13] There may be signs of tamponade, pulsus paradoxicus, dilated pulsating neck veins, reduced pulse

pressure. According to Wolff[9] and Barnes,[7] enlargement of the cardiac shadow by x-ray is due to cardiac dilatation rather than to large effusion, and is often of short duration.[10] Pericardial fluid aspirated by Porter et al[5] varied from only 90 to 160 cc. There are usually signs of pulmonary compression in the left chest and frequently small unilateral or bilateral pleural effusions which are exudative and not bloody.[11] Pleural friction rubs may be heard.

Laboratory examinations confirm the above physical findings. X-ray shows an enlarged cardiac shadow with decreased pulsations on fluoroscopy. Differentiation between pericardial effusion and cardiac dilatation by this method may be impossible. It would seem in these instances that the use of the arm to tongue circulation time suggested by Bellet et al[12] recently would be useful. They found this circulation time normal in large pleural effusion and prolonged in patients with cardiac dilatation. The sedimentation rate is elevated early in the disease and may persist as long as eight weeks.[5] Leucocyte counts average from eleven to eighteen thousand.[10] Polymorphonuclears are moderately increased.[5] Cold agglutinations[10] and other virus agglutination[6] tests are negative. Cultures of pericardial and pleural fluid are uniformly sterile. Electrocardiographic changes according to Porter et al[5] consist essentially of an initial elevation of the S-T segment with upright T waves. Within a few days to a week or more, the S-T segments become depressed with concomitant inversion of the T waves. These changes may occur in all limb and chest leads, or may be restricted to one or more leads.[10] Abnormal Q waves, intraventricular conduction defects and prolonged P-R interval, according to Brown,[10] are not seen in nonspecific pericarditis. Porter emphasizes the fact that electrocardiographic changes may be minimal or absent initially, may persist from a few weeks to as long as 2 months, but eventually revert to normal. Carmichael et al[1] alone report residual and presumably permanent T wave changes in six out of fifty cases.

The clinical course is variable with recurrences frequent. Barnes[7] reports one of his patients who had six recurrences. In my experience, two patients had had strongly suggestive similar experiences one to two years prior to the major attack. Both suffered recurrences after apparent subsidence of activity and both recurrences responded quickly to chloromycetin. In Porter's[5] series, the duration of fever varied from three to twenty-two days, terminating by lysis. Under treatment with aureomycin and terramycin[6,4] a dramatic response is reported. Within a day or so the patient feels better, the intense pain subsides, the tachycardia diminishes, and within three to four days the temperature may subside to normal and all pain may vanish. Pleural effusions in one of my patients subsided on two occasions within four days. In several of Rosenow's[4] and Taubenhaus'[6] cases, penicillin and streptomycin had been used without improvement. According to the former authors, the sedimentation rate elevation and electrocardiographic changes are unaffected by the use of antibiotic. Other measures of treatment consist of routine symptomatic relief including ice bags to the anterior chest and in the presence of tamponade and a presumably large effusion, pericardicentesis. The modes of approach recommended are either the apical or the abdominal routes.[14] The ultimate prognosis is felt by all authors to be uniformly good, without need for subsequent limitation of activity. To avoid recurrences, avoidance of upper respiratory infections or early treatment with antibiotics of the latter when they occur in recovered cases seems advisable.

An excellent differential diagnosis of acute chest pain was recently provided by Wolff.[11] He considered chiefly acute myocardial infarction, acute nonspecific pericarditis, pulmonary embolism and dissecting aneurysm, since all four conditions are characterized by chest pain, fever, leucocytosis, elevated sedimentation rate, and an abnormal electrocardiographic pattern. Rheumatic pericarditis and tuberculous pericarditis must be ruled out as well, mainly by the absence of evidence of these diseases elsewhere in the body than in the pericardium. The essential points differentiating nonspecific pericarditis from other conditions are, in summary, as follows: history of a preceding upper respiratory infection; relatively young age group; absence of previous hypertension or angina; aggravation of pain by change of position with partial relief by an upright position; fever, elvated sedimentation rate and friction rub dating from the onset of pain; presence of a small pericardial effusion, persistence of pericardial friction rub longer than a few hours; frequent pleuritic involvement; absence of pulmonary edema, typical serial electrocardiograms; relative absence of murmurs and joint involvement; negative bacteriological studies and blood chemistries.

BIBLIOGRAPHY

1. Carmichael, D. B., Sprague, H. B., Wyman, S. M., and Bland, E. T.: Circulation 3:321-331, 1951.
2. Barnes, A. R., and Burchell, H. B.: Am. Heart J. 23:247-266, 1942.
3. Wolff, L.: N. England J. Med. 230:422-425, 1944.
4. Rosenow, O. F., and Cross, F. J.: Arch. Int. Med. 87:795-807, 1951.
5. Porter, W. B., Clark, O., and Porter, R. R.: J. A. M. A. 144:749-753, 1950.
6. Taubenhaus, M., and Brams, W. A.: J. A. M. A. 142: 973-975, 1950.
7. Barnes, A. R.: J. A. M. A.. 144:733, 1950.
8. McCord, M. C., and Taguchi, J. T.: Arch. Int. Med. 87:727-731, 1951.
9. Wolff, L.: N. England J. Med. 229:423-431, 1943.
10. Brown, M. G.: N. England J. Med. 244:666-669, 1951.
11. Wolff, L.: N. England J. Med. 244:965-970, 1951.
12. Bellet, S., Nadler, C. B., and Steiger, W. A.: Ann. Int. Med. 34:856-861, 1951.
13. Soutter, quoted in "Medical Grand Rounds" Am. Practitioner 2:447-448, 1951.
14. Kotte, J. H., and McGuire, J.: Mod. Concepts Car-
15. Levy, R. L., and Patterson, M. C.: Am. J. Med. 8:34, diovasc. Dis. 20:102, 1951.
1950.

L. A. Clinical Session Aftermath

The atendance was far beyond all expectations. Registrations totaled 4,419 physicians and 4,656 guests for a total of 9,075, as compared with 2,160 physicians at the Cleveland meeting in 1950 and 1,781 guests for a total of 3,941. It was the biggest clinical meeting ever held. Thirty-nine newspaper and magazine writers covered the Los Angeles meeting—the largest group of writers ever assigned to "work" a clinical session. 4,149 persons viewed the specially selected medical motion pictures shown in connection with the Scientific Exhibit. This was a 1,029 increase over the Cleveland meeting.

Smith, Kline and French Laboratories of Philadelphia and the Laboratories Division of the Columbia Broadcasting Station were showered with congratulations for the fine job they did in televising a heart operation in full color to medical audiences in Chicago and New York. It was the first transcontinental transmission of color television—truly a milestone in medicine! . . . The wife of movie actor Spencer Tracy, mother of a deaf son, was a participant in the demonstrational lectures on Noise and Health at the Scientific Exhibit. . . . Registrations for the two-day Public Relations Conference, which preceded the clinical session, totaled 450—the biggest crowd ever to attend such a meeting. The well handled conference brought together doctors and lay personnel concerned with medical public relations for work sessions on problems confronting the profession.

It took one box car, loaded to the rafters, to haul all of the AMA convention paraphernalia from Chicago to Los Angeles. The car's contents ranged from gavels to a number of garbage cans which were used in connection with one of the scientific exhibits.

To give you an idea of the size of the crowd at the scientific and technical exposition hall, Abbott's served 9,150 persons, who consumed 315 gallons of coffee and 14,000 cookies sweetened with Sucaryl during the three and a half days.

Group Practice in Beverly Hills

A new concept in Private Group Practice—thirty-five well established doctors of medicine have joined in offering the necessary facilities under one roof for the complete medical and surgical care of the patient. The Beverly Hills Clinic, Beverly Hills, California, opened October 1, 1951. The new center, especially designed to fulfill this type of care, is the result of more than four years of study and research into the technical, administrative and personnel organization of successful clinics throughout the country.

Fifty medical and surgical specialists from Southern California staff the new four story building which also houses a fully equipped pharmacy, laboratory, physiotherapy and x-ray plant. Emphasis is placed on the individual patient with the same private office attention to which the patients are accustomed. All treatment is supervised by the patient's own personally selected physician.

The clinic operates a nurses' registry and a medical exchange, with physicians always on call day and night for those who need immediate care.

THE PRESIDENT'S PAGE

The one millionth death in this country as the result of automobile accidents was given dramatic emphasis just before the recent holidays by the newspapers and the radio. The National Safety Council some time previously had made the prediction that the millionth death from this cause for the period of approximately fifty years would occur at that time, and they were possessed of a certain gruesome accuracy. Just after the New Year our Highway Safety Commission came out with the statement that in Connecticut for the Year 1951 there were two million casualties by the same means—automobile accidents.

The automobile is only one of our modes of transportation, yet there are more operators of vehicles in automobile transportation than in the other methods of moving about, so that the need for individual responsibility, skill, training, and physical qualifications are more widely distributed.

Not only the number of accidents but death by accidental means is on the increase. In the past generation there have been fruitful campaigns directed against accidents put on by industry and other interested organizations—the "Safety First" slogan is widely familiar. The medical profession, interested insurance carriers, employers, workmen's organizations, and some government groups have all contributed important parts.

Accidental deaths, particularly those by means of transportation and specifically those by automobiles, show no sign of decreasing in this country in the predictable future. Might not the medical profession at this time fittingly increase its preventative endeavors in this field?

Brae Rafferty, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
Public Relations

160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

House of Delegates

The semi-annual meeting of the House of Delegates was held at the New Haven Medical Association on December 20 and was well attended. A report of the Society's activities for the past six months was presented by the President, Brae Rafferty, in which he highlighted the satisfactory financial operations of the Society and the importance of revival of interest in the Clinical Congress. Joseph Howard, Chairman of the Council and delegate to the American Medical Association, reported in detail on the meeting of the House of Delegates of the American Medical Association which had just been held in Los Angeles. The executive secretary reported on the gain in membership during the year 1951 and complimented the secretaries of the county medical associations on their continuous efforts to recruit new members. The total membership of the Society is the largest it has ever been.

BUDGET

The budget for 1952 totaling $90,265.32 was approved and the dues for 1952 were continued at $25.

SPEAKER OF THE HOUSE

The amendment to the By-Laws providing for a Speaker and Vice Speaker for the House of Delegates and which had been approved by most county associations was passed unanimously. The basic amendment provides for the annual election of a Speaker of the House of Delegates and a Vice-Speaker. The Speaker shall preside at all regular and special meetings of the House of Delegates except at such times as he may request the Vice-Speaker to preside during his temporary absence from the chair. He shall cooperate with the executive secretary and other officers of the Society in arranging the agenda for meetings of the House of Delegates and he shall appoint reference committees as provided in Article VII and VIII of the By-Laws, or as he may be directed by vote of the House. The Speaker of the House shall have the privilege of voting in the House of Delegates for the purpose of breaking a tie, and he may meet with the Council without privilege of voting, upon invitation of the chairman of the Council for the purpose of discussing procedure of the House of Delegates. The Vice-Speaker shall assist the Speaker in the discharge of his duties and in the absence of the Speaker or upon his request shall assume the duties of his office. In the event a vacancy occurs in the office of Speaker of the House of Delegates, the Vice-Speaker shall succeed to that office until the next annual meeting of the Society.

MEDICAL SERVICE IN THE WELFARE DEPARTMENT

Resolutions were presented to the House of Delegates for the Committee on Public Health, from the Eye, Ear, Nose and Throat Section and from the New Haven County Medical Association criticising the administration of payments for medical service by the State Department of Welfare as regulated by a recent decision of the Attorney General's for the State of Connecticut. It was voted that a special committee be appointed to confer with the Commissioner of Welfare and appropriate members of his staff with a view of correcting the present critical points. The Chairman of the Council appointed the committee as follows: Chairman, Joseph H. Howard, Bridgeport; C. Louis Fincke, Stamford; Dewey Katz, Hartford; James H. Root, Waterbury; William H. Upson, Suffield.

AMERICAN MEDICAL EDUCATION FOUNDATION

William G. H. Dobbs, chairman, reported for the Committee on Public Relations that is directing the Connecticut campaign for funds for the American Medical Education Foundation. The House voted to contribute $1,000 of the surplus funds of the Society to the Foundation. Report of the progress of the Connecticut campaign is published elsewhere in this issue of the JOURNAL.

PARTICIPATION IN MEDICAL SERVICE INSURANCE WRITTEN BY COMMERCIAL CARRIERS

Thomas J. Danaher, Torrington, reported for the Special Committee on Physicians' Relationship to Connecticut Medical Service Insurance that was authorized by the House of Delegates at the annual meeting, 1951. The report follows:

The House of Delegates, at its annual meeting in 1950, appointed a "Committee to Inquire into the Relationship of Members of the Society to Medical Care Insurance Written by Commercial Carriers."

It is the opinion of the Committee that the House of Delegates should take definite action on this problem in order to advise the members of the Connecticut State Medical Society regarding participation with commercial insurance carriers writing medical insurance.

The Committee wishes to bring to your attention that in 1947, the House of Delegates of the Connecticut State Medical Society declined to accept the report of the prepaid medical care committee whereby commercial insurance companies would underwrite a prepaid medical plan. It was the decision of the House of Delegates that the prepaid plan should be underwritten by a nonprofit corporation.

Connecticut Medical Service was organized as a result of this action in order that the majority of the people of Connecticut could insure themselves against the cost of medical care at a price they could afford to pay. The physicians of Connecticut agreed to participate in the plan. They are providing professional services at less than the usual fee to persons in certain income brackets, and are also agreeing to prorate their services, if necessary. In that way the participating physicians are coinsurers of the enterprise.

In the beginning, in order to get favorable coverage and reduce administrative costs, subscribers were enrolled in groups; now the Corporation is covering individual direct-pay subscribers. If Connecticut Medical Service is to attain the goal of insuring all of the people of Connecticut, it can be readily seen that it is necessary to continue to have large groups of employed people enrolled in the plan in order to absorb the poor risk and high administrative cost subscribers. Otherwise, the cost of the plan for people over sixty-five; people with recurrent illnesses who are no longer employed and individual direct-pay subscribers would be too great.

Commercial insurance companies are confining their coverage to good and average-risk large groups which lend themselves to easy administration, and by so doing they are attempting to take the cream and leave the skim milk to Connecticut Medical Service.

For many years commercial companies in the life and retirement income fields have limited their activities to the good risk and easy administrative groups. Today, in spite of their activity, we have National Social Security, indicating that insurance companies did not meet their social obligations to the people of this country.

Connecticut Medical Service has already allowed direct-pay enrollment, and, undoubtedly in the future, there will be a further broadening of the contract in order to allow enrollment of the bulk of the people of Connecticut. In this way, Connecticut Medical Service could be considered more of a social agency than an insurance company.

If commercial companies are willing to assume identical obligations as Connecticut Medical Service: namely, assume the same risks, have the same premium, have the same fee schedule and have a professional arbitration committee with authority—then Connecticut physicians should be ready to consider participating on an equal basis.

It is the opinion of this committee, at the present time, that the House of Delegates should advise the physicians of Connecticut not to participate with commercial insurance companies on a basis equal to Connecticut Medical Services. However, it should be understood that the Connecticut State Medical Society is in favor of commercial carrier coverage wherever Connecticut Medical Service is not readily applicable. The physicians of Connecticut should be willing to cooperate with these carriers in any way that will not jeopardize the continual growth of Connecticut Medical Service, which has pioneered in providing low cost prepaid medical care for all the people of Connnecticut.

James R. Cullen, M.D.
Christopher E. Dwyer, M.D.
Thomas M. Feeney, M.D,
Hyman A. Levin, M.D.
Thomas J. Danaher, M.D.

AMERICAN MEDICAL ASSOCIATION DELEGATES

Official notification has been received from the secretary of the American Medical Association to the effect that 2,371 members of the Connecticut

State Medical Society paid dues to the AMA for the year 1950, thus entitling the Society to continue being represented by three delegates in the House of Delegates of the American Medical Association during 1952. A number of States lost delegates because of nonpayment of AMA dues. The House of Delegates in Los Angeles voted that in the future dues to the American Medical Association must be paid by June 1 of each year, with one month of grace in order to give ample time to compute delegates' allotment by January 1 of the next year.

Full Time County Secretary

The staff at the State office welcomes Mr. James L. Gordon recently appointed full time executive secretary and public relations director for the Hartford County Medical Association.

Meetings Held in January

January 2—Connecticut Health League Program Committee

January 4—Program Committee for the Annual Meeting

January 9—Committee on Hospitals

January 10—Program Committee New England Health Council

January 15—Annual Meeting Connecticut Health League

January 16—Committee on Infant and Maternal Mortality

January 17—Nominating Committee
Council
Advisory Committee State Department of Education

January 22—Executive Committee Connecticut Cancer Society

Wanted

The response to the request for pictures of past presidents of the Society that was published in the January JOURNAL was most gratifying and a large number of pictures were added to the collection. The following are still missing and members are urged to help locate them. It is not necessary that the pictures be given to the Society. If they are sent to the secretary's office they will be photo-copied in standard format and returned promptly and in good order. If painted portraits only are available, the photographer will go where they are located and photograph them there.

1792 Leverett Hubbard, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1807 John R. Watrous, Colchester
1822 Thomas Hubbard, New Haven
1829 John S. Peters, Hebron
1832 William Buel, Litchfield
1834 Thomas Miner, Middletown
1837 Silas Fuller, Hartford
1841 Elijah Middlebrook, Trumbull
1843 Luther Ticknor, Salisbury
1851 Rufus Blakeman, Greenfield
1853 Richard Warner, Cromwell
1854 William H. Cogswell, Plainfield
1856 Benjamin H. Catlin, Meriden
1858 Ashbel Woodward, Franklin
1861 Josiah G. Beckwith, Litchfield
1865 Nathan B. Ives, New Haven
1866 Isaac G. Porter, New London
1867 Charles Woodward, Middletown
1868 Samuel B. Beresford, Hartford
1870 Charles F. Sumner, Bolton
1873 Ira Hutchinson, Cromwell
1874 Lowell Holbrook, Thompson
1875 Pliny A. Jewett, New Haven
1878 Charles M. Carleton, Norwich
1879 Alfred R. Goodwich, Vernon
1880 Gideon L. Platt, Waterbury
1882 William G. Brownson, New Canaan
1883 Elisha B. Nye, Middletown
1884 Benjamin N. Comings, New Britain
1885 Elijah C. Kinney, Norwich
1887 Francis Bacon, New Haven
1888 George L. Porter, Bridgeport
1889 Orlando Brown, Washington
1893 Francis D. Edgerton, Middletown
1895 Seth Hill, Stepney
1897 Ralph S. Goodwin, Thomaston
1899 Charles S. Rodman, Waterbury
1901 John H. Grannis, Old Saybrook
1905 Edward H. Welch, West Winsted
Nathaniel E. Wordin, Bridgeport
1930 Frederick G. Graves, Bethlehem

AMERICAN MEDICAL EDUCATION FOUNDATION

Fund-Raising Committee

CONNECTICUT STATE MEDICAL SOCIETY

Physicians who have contributed in the current campaign and those who have indicated they are contributing directly to their medical schools as of January 14

FAIRFIELD COUNTY

M. Abrahams, New Canaan
John D. Booth, Danbury
Philip R. Carrol, Jr., Bridgeport
Edwin R. Connors, Bridgeport
R. T. Davol, Greenwich
Ralph Edson, Derby
J. Benton Egee, Newton
C. Louis Fincke, Stamford
Wesley Fitzpatrick, Norwalk
Harold Genvert, Norwalk
Grace V. Gorham, Norwalk
R. Warren Hall, Trumbull
George W. Hebard, New Canaan
Joseph H. Howard, Bridgeport
Robert B. Huden, New Canaan
A. Boswell James, Bridgeport
Marjorie Knauth, Wilton
Neil F. Lebhar, Westport
Paul Lengyel, Bridgeport
Joseph P. Leone, Harwichport, Mass.
Fred A. Patterson, Norwalk
John S. Poczobut, Stamford
Harold Ribner, Bridgeport
Michael V. Sciortino, Bridgeport
Howard P. Sorrell, Greenwich
Milton Sheiman, Bridgeport
Samuel C. Sheiman, Bridgeport
Luther W. Strayer, Bridgeport
Francis B. Woodford, Ridgefield
Isidore Yasser, Bridgeport
John B. Zielinski, Bridgeport

HARTFORD COUNTY

Edmund Beizer, Hartford
Charles T. Bingham, West Hartford
James M. Bunch, Hartford
Marvin B. Day, Hartford
William J. Doerr, Hartford
R. E. Durkee, Hartford
R. M. Filson, Hartford
Forrest D. Gibson, Hartford
LeRoy C. Grau, Hartford
Dwight Griswold, Hartford
George M. Gura, Southington
Jack Gurwitz, West Hartford
Glover Howe, Hartford
Joseph F. Jenovese, Hartford
Robert Karotkin, Hartford
R. R. Keeney, Jr., Manchester
John Kennedy, Jr., Windsor Locks
I. W. Kingsbury, Hartford
Joseph Klein, Hartford
William J. Lahey, West Hartford
Raymond Lublin, East Hartford
George A. F. Lundberg, Manchester
Morris M. Mancoll, Hartford
Sidney R. McPherson, Hartford
James R. Miller, West Hartford
Joseph A. Mlynarski, New Britain
M. J. Morrisey, Hartford
Harriett E. Northrup, West Hartford
R. H. Osmond, Hartford
John V. Prignano, Manchester
Renato A. Ricca, Glastonbury
John C. Rowley, West Hartford
C. T. Schechtman, New Britain
W. B. Scoville, Hartford
E. Myles Standish, Hartford
Hilda C. Standish, West Hartford
James H. Standish, Hartford
Theodore W. Steege, Hartford
William F. Storms, Wethersfield
William H. Upson, Suffield
N. W. Wawro, Hartford
Stanley B. Weld, Hartford
Gideon R. Wells, Hartford
Benjamin B. Whitcomb, Hartford
Benjamin White, Hartford
H. B. Woodword, Bristol
Edmond R. Zaglio, Manchester
Norman Zeldis, Hartford

LITCHFIELD COUNTY

George Cushman, North Woodbury
T. J. Danaher, Torrington
M. M. Dickinson, Watertown
William G. H. Dobbs, Torrington
G. Robert Downie, Winsted
H. B. Hanchett, Torrington
Arthur H. Jackson, Washington
Aaron Levy, Winsted
William B. Lyons, Thomaston
Edwin G. Reade, Watertown
Daniel P. Samson, Thomaston
James T. Smith, Winsted
Edward H. Wray, Jr., Litchfield

MIDDLESEX COUNTY

Harriet Bixby, Mansfield Depot
G. M. Craig, Middletown
C. B. Crampton, Middletown
Richard F. Grant, Cromwell
Carl C. Harvey, Middletown
Walter R. James, Essex
Louis O. LaBella, Middletown
V. G. Ryan, Portland
A. W. Thomson, Jr., Middletown

NEW HAVEN COUNTY

Creighton Barker, New Haven
Samuel S. W. Black, New Haven
Eugene M. Blake, North Haven
John A. Chasnoff, West Haven
Thomas Cottiero, Waterbury
Hermann S. Cutler, New Haven
Arthur Bliss Dayton, New Haven
Clyde L. Deming, New Haven
William Finkelstein, Waterbury
Joseph A. Fiorito, New Haven
Russell V. Fuldner, New Haven
Henry A. Geib, Milford
William Goade, Needham, Mass.
Morris Goldstein, New Haven
W. M. Good, Waterbury
Morris Hankin, New Haven
James E. Harty, Waterbury
Albert E. Herrmann, Waterbury
Robert H. Jordan, New Haven
H. Krochmal, Meriden
Jerome A. L'Heureaux, Meriden
Thomas P. Murdock, Meriden
Richard Newman, New Haven
Edward W. Oxnard, Cheshire
Gioacchino S. Parrella, Milford
John P. Riesman, New Haven
Milo P. Rindge, Madison
Bernard A. Rogowski, New Haven
Wilder Tileston, New Haven

NEW LONDON COUNTY

Henry Archambault, Taftville
F. C. Barrett, Jewett City
Louis Guss, Norwich
F. B. Hartman, New London
Morris Katz, Norwich
Winfield O. Kelley, Norwich
Martin L. O'Neill, Jewett City
William H. Pomeroy, Poquonock
Richard M. Starr, New London
John W. Suplicki, Norwich

TOLLAND COUNTY

William G. Luckner, Stafford Springs
Sayer E. Medbury, Columbia
E. H. Metcalf, Rockville

WINDHAM COUNTY

J. W. Major, Willimantic
Richard V. Newcomb, North Windham
E. J. Ottenheimer, Willimantic
Karl T. Phillips, Putnam
Brae Rafferty, Willimantic
W. M. Shepard, Putnam
N. Spector, Willimantic
John A. Woodworth, Moosup

THE HISTORIAN'S NOTE BOOK

A REVIEW OF "AN EARLY AMERICAN EXPERIMENT IN SOCIALIZED MEDICINE," BY EVERETT S. BROWN

ARTHUR S. BRACKETT, M.D., *Bristol*

THIS might well have been called "An Early Trial of the Practice of Medicine at the Federal Level."

Dr. James Smith of Baltimore, Maryland practiced there in the early nineteenth century and was among the first to use the "kinepox" (1801) in the prevention of smallpox. While on duty at the almshouse the reports of his cases were so "accurate and convincing" that the medical and chirurgical faculty endorsed him. With the help of the faculty and others he established the second vaccine institute in America, where the vaccine matter was propagated and distributed free to the poor.

So successful was he that he was appointed by President Madison as vaccine agent for the United States, under a law passed by Congress on February 27, 1813, "To appoint an agent to preserve the genuine vaccine matter, and to furnish same to any citizen of the United States whenever it may be applied for, through the medium of the post office."

He was required to send a copy of the act to every postmaster in the United States, where the copies were to be posted, informing the public when and where the vaccine could be obtained. The act further stated that "all letters or packages not exceeding half an ounce in weight, containing vaccine matter, and that alone," would be carried in the mails free. He must further subscribe his name to any letter with the word "Vaccination" on the outside, and a previous specimen of his signature must have been furnished the postmaster where the letter was mailed.

The discharge of the agent and the appointment of his successor was in the discretion of the President.

In 1801 Dr. Smith used vaccine at the almshouse from the second vaccine supply received in Baltimore and in 1809 he became Maryland's state vaccine agent. His term of service as a Federal official dated from 1813 to 1822, during which he supported through private donations 20 special agents with their horses. These agents gave 6,750 days' service and vaccinated rich and poor alike.

But, notwithstanding the success of the kinepox in preventing smallpox, there was a growing opposition in Congress, where many thought that such action should properly be left to the States and the people to handle.

This was brought to a head by an error of Dr. Smith which resulted in a special committee of Congress and his dismissal from his post by President Monroe. According to a letter from Dr. Smith to Congress there had been an unfortunate mistake, by which there was sent a package of smallpox scabs instead of vaccine. Several persons died. An immediate supply of vaccine was sent, many vaccinations were done and the epidemic was stopped.

A very full and interesting account of the arguments pro and con from a constitutional standpoint is given in the article reviewed. Other than this, in no place in the literature have I seen mention of a Federal Vaccine Agent. It seems that such mention should be made in a medical magazine, where those interested in the history of medicine would be likely to see it.

BIBLIOGRAPHY

1. Michigan Alumnus Quarterly Review, Vol. LVII, May 26, 1951, Number 18, pp. 226-234.

2. Aesculapius Comes to the Colonies, p. 244, by Maurice Bear Gordon, M.D., Ventor Publishers, Inc., 1949.

A STUDY OF BLUE CROSS COVERAGE AND HOSPITAL CHARGES

How much hospital care does the Blue Cross dollar buy? With 50 per cent of the Connecticut population now enrolled in Blue Cross, that question concerns the physician as well as the patient. Budget minded people, aware of high hospital costs, will bring their financial worries into the consulting room. For over half of them, Blue Cross benefits determine to a great extent how serious these worries will be.

Last year Connecticut Blue Cross bought more hospital care than ever before in its 15 year history. While final figures for the year are not yet available, a close-up study of the second quarter of 1951—just after the revised Blue Cross program went into effect—gives a fairly accurate picture of Blue Cross coverage under present conditions.

During these three months, April through June, Connecticut Blue Cross paid out $3,890,000 for members' care. In the same period, total plan income was $4,228,000 revealing an immediate cash payoff to hospitals of 92 per cent of earnings. Blue Cross operating expense for the period, including all equipment and salaries, totalled 5.4 per cent of income. The remaining 2.6 per cent went into reserves for future hospital care.

With assurance of a 92 cent average return on his membership dollar, the Blue Cross subscriber might leave the matter there. The professional man will have more questions to ask: how was the nearly four million distributed? How does it look on a per case and per diem basis? How do special service payments compare with room and board?

Basic to these questions is an understanding of the Blue Cross - Hospital Agreement. Figures quoted here are hospital charges—not, necessarily, hospital costs. The hospital bills the Plan for care furnished according to its regular published charges, and Blue Cross pays this amount. Final payments are subject to adjustment on December 31, based on detailed cost studies covering the 12 month period.

With this system in mind, let us narrow the focus and see how second quarter payments break down by day and by case. These and following tables, by the way, are based on payments to Connecticut Blue Cross member hospitals, which represent 93.7 per cent of all cases studied.

BASIC 21 DAY PERIOD CARE

PER DIEM BASIS

1. Hospital charge to Blue Cross	$ 17.30
2. Hospital charge to member	3.61
3. Hospital charge to Blue Cross and member	$ 20.91

PER CASE BASIS

1. Hospital charge to Blue Cross	$110.72
2. Hospital charge to member	23.10
3. Hospital charge to Blue Cross and member	$133.82

HOSPITAL CHARGES AND MEMBER'S BENEFIT

This study, also based on the second quarter of 1951, breaks down the charges by type of services and relates them to average length of stay:

A. BASIC 21 DAY PERIOD

ITEM	NON MATERNITY
1. Average stay	6.4 days
2. Hospital charge for bed and board (per day)	$12.11
3. Hospital charge for CBC special services (per day)	9.10
4. Hospital total charge (including non CBC service) (per day)	21.32
5. Member's benefit (per day)	17.71
6. Balance due from member (per day)	3.61

ITEM	MATERNITY
1. Average stay	5.9 days
2. Hospital charge for bed and board (per day)	$13.72
3. Hospital charge for special services (per day)	5.81
4. Hospital charge for care of newborn (per day)	2.83
5. Hospital total charge (per day)	$22.36
6. CBC payment (also member benefit) (per day)	$16.32
7. Balance due from member per day	6.04

B. 90 DAY BENEFIT PERIOD

In addition to the 21 day basic period, Blue Cross provides a $4.50 flat credit for an extra 90 days each calendar year. During the period studied, only 6 per cent of all cases were concerned with this benefit, indicating the breadth of coverage furnished under the 3 week time allowance for full benefits. Of total inpatient days, around 11 per cent came during the 90 day period.

C. TOTAL INPATIENTS

This table combines Basic Period, Maternity, and

90 Day Period to give a composite picture of all Connecticut Blue Cross inpatient member-hospital business:

ITEM	
1. Average stay (days)	7.1
2. Hospital total charge (per case)	$147.54
3. Member benefit (per case)	112.39
4. Balance due from member (per case)	35.15

Percentage computations based on Items 2 and 3 show that Blue Cross covered 76.2 per cent of the total hospital bill during the April-June period. It is worth noting that the average amount charged to the patient, as shown above (Item 4), was about one-third less than in the previous quarter before the increased Blue Cross program went into effect. This high coverage becomes more significant when you take into account that 17.2 per cent of all days were in private room accommodations, where the room rate is beyond reach of the $9 standard Blue Cross room allowance.

SPECIAL SERVICES AND TOTAL CHARGES DURING BASIC 21 DAY PERIOD

Complete coverage of Blue Cross special services during the 21 day period is the heart of the Blue Cross program and takes on added importance for the member as special services increase in variety and cost.

Unfortunately, special service statistics must be qualified somewhat because of lack of uniformity among hospitals in their charging practices. Some hospitals allocate practically all charges to the class of service concerned, while others apply a miscellaneous flat service charge to such items as laboratory, drugs, dressings, etc. While this distorts the following tables for some individual items, it is felt that the following categories present a fairly accurate picture: operating room, oxygen, physiotherapy, electrocardiogram, and basal metabolism; also x-ray and anesthesia, but to a lesser degree.

AVERAGE SPECIAL SERVICE CHARGES FOR ALL BASIC (21) DAYS

The following breakdown shows special service charges in Connecticut member hospitals during the second quarter of 1951. These are averages for all Blue Cross basic days and do not reflect the hospital's charge for a particular service.

	PER DIEM	PER CASE
Operating room	$1.91	$12.22
Laboratory	1.88	12.03
Anesthesia	1.08	6.91
X-ray	1.79	11.46
Physiotherapy	.05	.32
All other CBC services	2.40	15.36
Total	$9.11	$58.30

AVERAGE CHARGE PER SERVICE ITEM

This study shows the hospital's average charge to all members who were billed for the same item of service; also the percentage of all cases so billed:

	AVERAGE CHARGE	PER CENT OF CASES BILLED FOR SERVICE
Operating room	$19.23	62.9
Laboratory	12.97	92.4
Anesthesia	14.06	49.0
X-ray	25.77	44.3
Physiotherapy	13.30	2.2
Drugs and serums	14.30	75.7
Dressings and casts	2.67	10.7
Oxygen	27.21	4.6
Electrocardiograms and basal metabolism	16.14	7.3
Other	9.57	17.8
Total	$58.64	98.8

You will note that 62.9 per cent of all cases were billed for operating room and 49 per cent were billed for anesthesia. Most of this difference (approximately 3,000 cases) is due to the fact that in a few hospitals anesthesia is handled on a private physician basis with no Blue Cross benefit under the circumstances.

SPECIAL SERVICES AND TOTAL CHARGES BY INDIVIDUAL MEMBER HOSPITAL (1ST HALF 1951)

This study sets forth, by individual Member Hospital, their charges during the basic 21 day period of our program. Just a word of caution before you label a hospital as either "high-charge" or "low charge" based on these data; here are some of the reasons:

1. Some hospitals provide services which are not available in other hospitals: for example, anesthesia, x-ray therapy, certain drugs, etc.

2. The medical staff of one hospital may prescribe more services than the staff of another hospital; they may admit patients unnecessarily or hospitalize them longer than other hospitals. This situation can even be affected by the concern or lack of concern on the part of the hospital administrator and even the trustees.

HOSPITALS BY NO. ADULT BEDS	AVERAGE STAY (DAYS)	CHARGES FOR CBC SPECIAL CHARGES		TOTAL CHARGES		PER CENT TOTAL MEMBER HOSPITAL DAYS
		PER DIEM	PER CASE	PER DIEM	PER CASE	
Hartford 869	7.3	$9.02 (14)	$66.05 (6)	$23.18 (7)	$169.83 (2)	10.9
New Haven 542	8.1	8.59 (18)	69.30 (5)	23.41 (5)	188.78 (1)	6.7
St. Francis 535	7.2	8.36 (22)	60.50 (11)	19.56 (22)	141.48 (12)	9.0
St. Raphael 370	7.5	8.01 (25)	60.28 (13)	19.47 (23)	146.49 (9)	7.7
Bridgeport 366	7.5	8.04 (24)	60.45 (12)	20.36 (16)	153.05 (5)	4.7
St. Vincent's 345	6.2	8.69 (17)	54.09 (18)	20.74 (15)	129.18 (17)	4.9
St. Mary's 327	6.6	7.73 (26)	50.86 (23)	17.92 (27)	117.82 (22)	8.4
Waterbury 324	6.4	8.84 (15)	56.69 (15)	20.36 (17)	130.50 (16)	7.2
New Britain 267	7.4	11.10 (4)	82.10 (1)	22.46 (10)	166.13 (4)	3.4
Norwalk 247	6.2	9.04 (13)	55.78 (16)	21.72 (11)	134.01 (14)	3.5
Lawrence and Memorial.... 233	5.6	9.28 (11)	51.84 (22)	21.21 (13)	118.48 (21)	2.3
Stamford 232	7.0	9.33 (10)	65.70 (7)	21.57 (12)	151.94 (6)	1.2
Danbury 168	6.5	8.20 (23)	53.51 (19)	20.01 (20)	130.62 (15)	2.6
Grace Unit 163	6.5	10.61 (5)	69.38 (4)	25.51 (1)	166.82 (3)	3.3
Bristol 160	6.2	10.01 (7)	61.62 (10)	23.36 (6)	143.87 (10)	3.0
Manchester 155	5.2	8.54 (19)	44.10 (26)	19.73 (21)	101.86 (29)	1.9
Middlesex 150	6.3	9.99 (8)	63.08 (8)	22.73 (9)	143.59 (11)	2.2
Backus 143	5.1	11.79 (3)	59.71 (14)	24.51 (3)	124.14 (19)	1.1
Greenwich 128	6.0	8.81 (16)	52.93 (20)	20.76 (14)	124.69 (18)	.4
Hungerford 128	7.3	8.45 (20)	61.82 (9)	20.22 (18)	148.03 (8)	2.6
Meriden 121	5.1	10.24 (6)	52.30 (21)	22.89 (8)	116.85 (23)	2.6
Mt. Sinai 115	6.0	11.85 (2)	70.55 (3)	25.28 (2)	150.43 (7)	2.0
St. Joseph's 99	5.4	9.36 (9)	50.64 (24)	19.23 (24)	104.03 (28)	.6
Windham 96	5.0	9.26 (12)	45.92 (25)	20.07 (19)	99.46 (30)	1.0
Griffin 92	6.2	6.93 (29)	43.23 (27)	17.77 (28)	110.82 (24)	1.4
Litchfield 71	6.4	8.45 (21)	54.46 (17)	18.51 (25)	119.20 (20)	.8
Day Kimball 70	6.7	6.04 (32)	40.60 (29)	15.53 (32)	104.41 (27)	.8
Sharon 55	5.9	7.03 (28)	41.41 (28)	17.73 (29)	104.51 (26)	.2
Rockville City 50	6.5	5.27 (34)	34.21 (34)	12.51 (34)	81.18 (33)	.4
Bradley Memorial 50	5.6	6.89 (30)	38.84 (30)	16.22 (30)	91.36 (32)	.9
Johnson Memorial 50	5.3	6.89 (31)	36.72 (33)	15.08 (33)	80.39 (34)	.3
Milford 50	5.1	7.62 (27)	38.52 (31)	18.16 (26)	91.78 (31)	.6
Park City 35	5.8	12.31 (1)	71.70 (2)	23.80 (4)	138.64 (13)	.6
New Milford 26	6.5	5.87 (33)	38.23 (32)	16.06 (31)	104.56 (25)	.4
Total Connecticut Member Hospitals	6.7	8.83	58.74	21.00	139.71	99.6

(Rank from High to Low)

Preventive Aspects of Chronic Disease, A Public Responsibility

The Connecticut State Department of Health and the Commission on the Care of the Chronically Ill recently held a joint all-day symposium on the preventive aspects of chronic illness. The papers presented at that meeting by individuals nationally known in this field have been collected in pamphlet form and released for distribution. It should be read and seriously considered by every practitioner of medicine, welfare agent, social service worker, public health officer, and by all officials who are interested in the relation of government to the welfare of the people.

If we are to combat socialized medicine on a wide scale successfully and prevent bureaucratic control at high levels, we must see to it that good results are obtained locally at grass-roots levels. We will not succeed by attacking efforts at social and medical betterment of the people and, at the same time, deny means and measures which aim to provide such betterment, within a sound framework of economy and a minimum of dictation.

It has always been gratifying that Connecticut has taken an advanced and pioneering approach to welfare problems. Indeed, sister States at times have sought our advice and subsequently flattered us by imitation. Certain historical landmarks prove that many important contributions to these social problems have been made by members of the Connecticut State Medical Society.

Ten years ago Governor Raymond E. Baldwin, becoming alarmed over the situation in the mental hospitals, called upon a Commission to study the problem and make suggestions for legislation, looking to the relief of their burdens. The Chairman of that Commission was Dr. Creighton Barker. Other members of the Commission included: Dr. Wilmar Allen, of the Hartford Hospital; Professor Ira Hiscock, of the Department of Public Health; Mr. Lucius Robinson, Jr., an attorney of Hartford; and Mr. Joseph Downes, who was then a member of the State Senate and who has since served as one of the State auditors.

Some years before this, old age benefits had been accorded to those who reached mature years and who had been retired from industry by reason of age and who, for various reasons, had not been able to provide for their declining years. The Barker Commission called attention to the fact that this was a new venture for public funds. Prior to that time, care of the mental illnesses and tuberculosis had been based on "police power," acting simply to protect the community. Care of the needy had always been provided by the town of residence, the State taking care of those few vagrants who had not established any specific residence.

The Barker Commission found that numerous of these aged individuals without domicile had been committed to the State mental institutions for care. The next session of the General Assembly commissioned the Public Welfare Council to make a study of the facilities needed to accommodate this type of patient and thus relieve the mental institutions of this responsibility. A report of this study proposed the establishment of three large institutions to house the most urgent cases and suggested that smaller accessory units might later have to be added. The cost of such a procedure apparently seemed too great and action was delayed. Shortly, however, medical and hospital benefits to the recipients of Old Age Assistance were added to their original grants. This action put the burden and proper handling of these cases largely up to the medical profession. A most difficult type of service to provide for, was seen in the so-called terminal care case.

A highly constructive approach was made by an Act of the General Assembly in 1945. A committee was appointed of which Dr. A. N. Creadick was chairman, and other members were Dr. Joseph H. Howard, Mrs. Frances Redick, Mr. John Lamb, and Dr. James McConaughy. The Commissioner of Welfare and the Commissioner of Health were made ex officio members. The enlightened approach in this Act was seen in a list of powers and duties, for the Commission was required to "coordinate existing agencies" and "cooperate with existing facilities." Thus public officials were now thinking in terms of the cooperative use of services that might be available in existing forms rather than the creation of additional new units. Individual members of this committee made numerous visitations, studied different phases of the problem, including all forms of custodial care. Recommendations of social agencies were subjected to severe scrutiny. The Welfare Council investigated and licensed boarding homes, including the few town poor houses that remained. The Department of Health surveyed and licensed nursing homes, convalescent homes, for any custodial care of bedridden persons. The Public Assist-

ance officers found difficulties in finding quarters for terminal care cases or severely handicappd cases requiring full nursing service.

The reports of this Commission through the years have shown the results of pioneering endeavor in an approach to these questions on a scientific basis. The problem was well expressed by the chairman in stating "the choice rests between old-fashioned custody of the apparently hopeless case in increasing numbers and in more and more institutions, versus a dynamic preventive and alleviating approach offering hope and something to look forward to;" in other words, the preventive aspect. To one group who demanded more terminal care for cancer cases it was suggested that earlier and better treatment of cancer would obviate such a great necessity for terminal care beds, and that the same approach might defer or alleviate many of the deteriorating diseases. It was pointed out that a study of these conditions would require that more and more of such patients should be accommodated in a facility adjacent to good laboratories and be given the best of medical care. Up to that time there had not been many chronic disease hospitals thus provided. How they should be housed and staffed, and what was the best size had not been determined. The United States Public Health Service, with a wide experience with general hospitals, had not established standards for chronic hospitals at that time.

The Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm recommended they be given an opportunity to start a pilot study unit to solve some of the hitherto unanswered questions, and to subsidize wards in such general and city hospitals as would cooperate by organizing departments of rehabilitation and make beds available to the various Welfare agencies to care for their patients. Dr. Howard secured the consultative services of Dr. Howard Rusk, who had created the rehabilitation services with the Armed Forces in World War II.

Subsequently Dr. McConaughy was elected Governor and resigned from the Commission; Mrs. Redick was elected Secretary of State and also resigned. Their places were taken by Mrs. Eleanor Laggren and Mr. Curtiss S. Johnson. Upon the untimely death of Mr. John E. Lamb, Mrs. Elizabeth B. Gillie, who had served in the Assembly as a representative from New Haven, was appointed, and upon the resignation of Mr. Curtiss Johnson, Dr. James Raglan Miller was appointed. Mr. Herbert Crapo was also a member of this Commission, being replaced by Father McMahon, now on the current Commission. The other members of the current Commission are Dr. John C. Leonard, Miss Helen Smith, and Mrs. Elinor Bissell.

When Dr. McConaughy became Governor, he suggested that the program might be activated more quickly if the Commission had a medical director, and Dr. Creadick resigned from the Commission and was appointed to fill that position. As a trustee of the American Medical Association, Dr. Miller had been appointed to the new National Commission on Chronic Illness, raised jointly by the American Medical Association, American Dental Association, American Public Welfare Association, and the American Public Health Association; thus providing a liaison between the Connecticut group and the National group which has proven most beneficial to both. A pilot study unit was instituted jointly with the Veterans Home and Hospital Commission at the Veterans Home and Hospital. Here a complete unit of physical medicine and rehabilitation was established. Furthermore, by grants in aid, several general hospitals were able to open wings devoted to rehabilitation of chronically ill patients. A small hospital for chronic illness under the charter of the City of New Britain was enlarged to accommodate a few female patients. This has given considerable practical experience to the Commission and they have applied to the several sessions of the General Assembly for the establishment of larger units in other strategic locations.

It would appear that there are two general avenues for the relief of this problem: (1) the question of medical rehabilitation, and (2) the housing of the rehabilitated person who is not able to live in a normal manner within the population at large. It seems most important that every facility be provided to continue this work.

There is every reason why a uniform general physical examination should be required of every applicant for old age assistance when he applies. This is no more an infringement of his free choice of physician than the examination required by an insurance company for an insurance policy. The State has agreed to provide hospital and medical benefits and currently is paying for the care of many of these people in the various types of homes and hospitals. It would seem to be in order to require an annual physical check up, which might discover disease in early stages and serve to benefit conditions

already established. Such a course should reduce the load of service the State is required to provide. When the State has undertaken to meet the need of care for the long continued illness, the provision of a certain amount of supervisory care by the State is a sequence dictated by common sense. Thus the preventive aspects of chronic illness deserve ever increasing attention on the part of those public officials to whom the responsibilities of the care of these unfortunate citizens has been delegated. It is hardly to be questioned that the medical profession is solidly behind such forward thinking.

LETTERS TO THE EDITOR

Veterans Administration
Hartford 4, Connecticut
Regional Office
95 Pearl Street

To the Editor:

We have been informed by our Central Office that some fee-basis physicians are prescribing alcoholic beverages for veterans in connection with authorized outpatient treatment. Our regulations prohibit prescribing alcoholic beverages for medicinal purposes. It will be necessary to prescribe, in lieu of alcoholic beverages, other suitable recognized therapeutic agents.

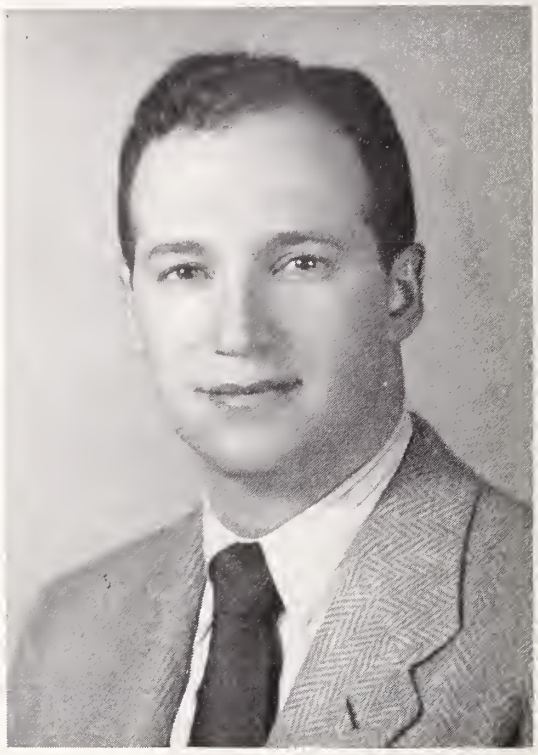
S. A. Schuyler, M.D.,
Chief Medical Officer

THE DOCTOR'S OFFICE

Joseph B. Cherry, M.D. announces the opening of an office for the practice of surgery at 345 Main Street, Danbury.

Chester W. Fairlie, Jr., M.D. announces the opening of an office for consultation in problems of diagnosis and therapy in the field of internal medicine and gastroenterology at 85 Jefferson Street, Hartford.

Joseph L. Gordon



Joseph L. Gordon has been appointed executive secretary of the Hartford County Medical Association, it was announced recently by Dr. James R. Gullen, president.

The appointment furthers action taken at the Association's annual meeting last year, when it was voted to employ a full-time executive secretary and develop a long range administrative and public relations program.

Formerly advertising and business manager for the *Brookline (Massachusetts) Chronicle*, Mr. Gordon is a graduate of the University of California, Class of 1947. He received a master's degree in business administration at Boston University in 1949.

Mr. Gordon served as an army correspondent in the Pacific during World War II. In 1945 he was connected with the sports department of the *Honolulu Star-Bulletin* and later became a staff writer for the United Press. He is a member of the American Legion, Veterans of Foreign Wars and Sigma Delta Chi, professional journalism society.

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
John E. Flaherty, Rockville
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Emergency Medical Call System for Middletown Area

A special committee of the Central Medical Society, Middletown is studying plans for early inauguration of a modern emergency medical call system.

The committee was appointed recently by Harry C. Knight, president of the Society, who is also chairman of the Public Relations Committee of the Middlesex County Medical Association.

Henry D. Sherwood is chairman of the committee planning the Middletown service. The proposed system would be operated through a central switchboard and extend to adjacent communities. It is anticipated it will be ready for operation within a few weeks.

The Middletown service is to be sponsored by the Central Medical Society in cooperation with the Middlesex County Medical Association. The project is part of a county-wide program to study and improve emergency facilities, now being conducted by the County Association's Committee on Public Relations.

Public Relations Committee Appointed in Fairfield County

Appointment of a Public Relations Committee was announced recently by the Board of Trustees of the Fairfield County Medical Association.

Frank C. McMahon, Stamford, chairman of the committee, is the Association's representative on the Public Relations Committee of the State Medical Society. Other members of the Fairfield County committee are D. Olan Meeker, Riverside; Ward B. DeKlyn, Danbury; Nicholas P. R. Spinelli, Stratford. Another committe member is soon to be appointed from the Norwalk area.

Announcement of the new committee follows action taken at the Association's semi-annual meeting last October, when it was voted that a Committee on Public Relations be appointed.

Oliver L. Stringfield, Stamford, president of the Association, stated in a January newsletter the committee will be one of the most important in the organization. An early meeting is planned to study development of public relations services and activities.

Connecticut PR Leaflets Distributed by AMA

Sample copies of the State Medical Society's two leaflets concerning the services of medical organizations, titled "Serving Physicians, Serving the People," are being distributed by the American Medical Association to State and metropolitan county associations.

Samples of the leaflets are included in the Exchange Kit of the January issue of *PR Doctor*, issued by the AMA Public Relations Department for guidance of medical organizations in developing their programs. Describing the leaflets, *PR Doctor* comments: "Folks say that on occasion 'the truth hurts,' but more and more medical societies are coming around to the opinion that lack of truth can be much more painful. It is becoming increasingly important that the public as well as physicians have access to information about medical organizations."

Annual PR Conference Attracts Record Attendance

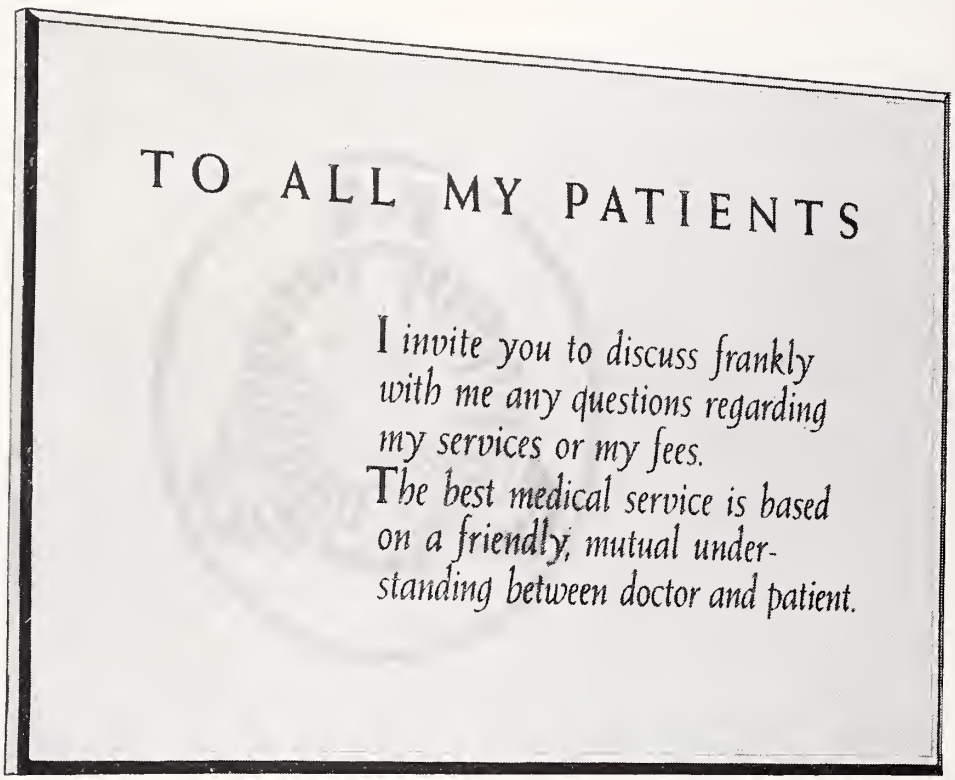
More than 500 medical society executives, delegates and public relations directors attended the Fourth Annual Medical Public Relations Conference in Los Angeles December 2-3, preceding the American Medical Association's Clinical Session.

Theme of the two-day session was "Joining Forces for Public Relations in 1952." Dr. Louis A. Bauer, AMA president-elect and principal conference

announcing

A NEW PUBLIC RELATIONS AID

. . . to boost your PR rating



NEW OFFICE PLAQUE

- ✓ dark brown lettering on buff
- ✓ harmonizes with any office decor
- ✓ measures 11½ by 7¾ inches
- ✓ for desk or wall
- ✓ laminated plastic finish

As you know, a physician's best public relations is carried on right in his own office. Here the physician gets acquainted with his patients . . . gives them a chance to talk over problems . . . builds a feeling of mutual understanding between patient and doctor.

Your American Medical Association has designed an attractive new office plaque to be displayed prominently on an office desk or wall. This is a graphic invitation to patients to talk over professional services and fees. Patients like to ask questions, but often are hesitant to do so. This plaque will open the door to better relations with your patients. Order one today.

PRICE
$1
POSTPAID

Order Department
AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago 10, Illinois

speaker, stressed the importance of community action programs in creating good public opinion for medicine. He strongly attacked socialistic trends and urged physicians to assume more active roles as community citizens in 1952.

A digest of conference proceedings is now in preparation and copies may be ordered through the Public Relations Department, American Medical Association.

A Leading Problem

The costs of sickness constitute a leading problem in medical public relations. Medical societies report the majority of complaints that reach their grievance committees involve medical costs. Continuing studies by the American Medical Association indicate five steps that individual physicians may take in helping to meet this problem, as follows: (1) discuss fees in advance with patients; (2) explain "those other medical bills" submitted by specialists and medical assistants; (3) itemize bills; (4) help patients budget for long-term medical care and (5) maintain good relationships in account collections.

A Note on General Practice in Great Britain

In a discussion at a recent meeting of the General Practice Review Committee of the British Medical Association it was emphasized that the National Health Service has accelerated the widening division between general practice and special practice to a degree that the interchange from the former to the latter has become almost impossible. It was pointed out that in the original plan for a national health service the role of the general practitioner was that of treating minor ailments, sorting out all of the remainder and passing them on to the appropriate specialist for treatment. According to the Dr. F. M. Rose,* "This machine-belt system, with its reverence for specialists or super-doctors, has its special appeal to the doctrinaire, who see no reason why the general practitioner should demur. Only the determined stand of the medical profession has saved us from such a system. . . . The general practitioner is still the keystone of the whole Service, and any deterioration in his quality will be felt adversely in all the other branches of the Service. He must remain as the personal doctor of the patient—the known and respected figure to whom the patient may return after the confusion and anonymity of registrars and house-men and what not in hospital." Dr. Rose emphasizes that there is a particular field of the general practitioner in which he is expert and lists the following:

The extremes of life—childhood and old age.

Domiciliary midwifery.

Social medicine: (a) environmental, (b) industrial.

Infectious diseases.

The beginnings of disease processes, with special reference to the early diagnosis of (a) acute disease requiring early surgical intervention, and (b) malignant disease.

The domiciliary treatment of the closing stages of malignant disease.

The long continued treatment of the chronic disabling diseases which seldom enter hospital.

The giving of advice and guidance on a host of problems, personal and marital, entering into whole range of human relationships.

The adjudication of employability.

Certification: (a) National Health Service, (b) other.

Medical ethics.

This list it not regarded to be final, says Dr. Rose, and is of course not the whole range of general practitioner work. The remedy according to him is the establishment by general practice of a corporate body of its own bearing relationship to general practice as the Royal College do to special practice.

This report of the British Review Committee has its lessons for American Medicine as do many other experiences of British medicine under a government controlled system. It is important for us to consider similar trends in our own country and to recognize the work that the American Academy of General Practice and its State groups are doing toward the maintenance and healthy development of general medical practice.

*Rose, F. M.: General Practice and Special Practice. Supplement to British Medical Journal, October 27, 1951, p. 2440.

Members Who Have Entered Military Service

Capt. Edward Foord (formely of New Haven)
Hq. Co. Sec. 3,3431, ASU
U. S. Army Hospital
Fort Jackson, South Carolina

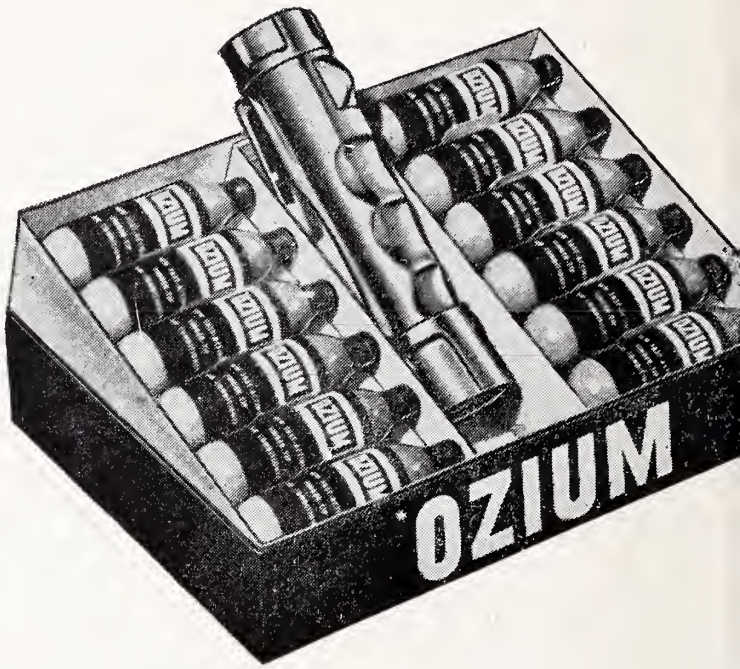
GOOD SERVICE

EXPERIENCED PERSONNEL

APPROVED EQUIPMENT

is the prescription that makes *American*

THE LEADER IN CONNECTICUT



If you wish our representative to call PHONE 5-3116 or ENTERPRISE 3190 . . . . or fill in the inquiry slip and mail today.

The American Surgical Supply and Equipment Co.
Bridgeport, Conn.

Gentlemen: Kindly have your representative call on

Date..... Time.....

I am interested in:

SPENCER SIGNS ☐ OZIUM ☐ RALK'S IDEAL UNIT ☐

Dr. .....

Address .....

.....

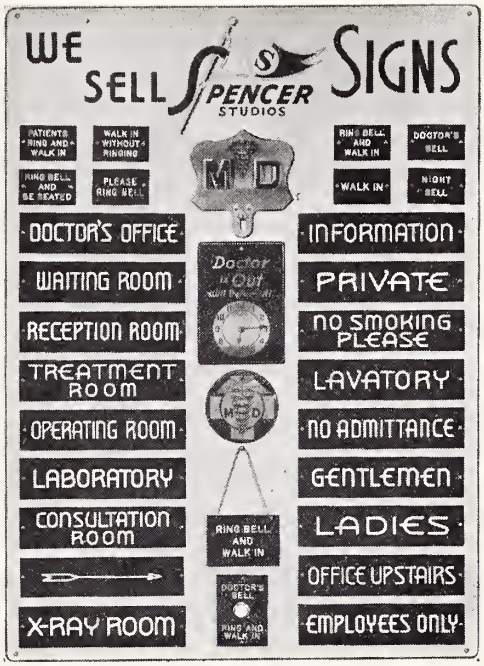
American Surgical

SUPPLY AND EQUIPMENT COMPANY

P. O. BOX 150, 1715 BARNUM AVE., BRIDGEPORT

SPENCER SIGNS

Engraved Bakelite Signs
and metal Auto Emblems



UM, new GLYCOL-IZED AIR FRESHENER

his new, scientific air-sanitizer acts fast. A finger-tip touch and Ozium goes work destroying air-borne germs and virus. In doctors' waiting rooms nd offices, in public clinics, in hospital rooms, wards, and operating rooms, zium lowers the risk of cross-infection from air-borne pathogens, as well as moves unwanted odors quickly and efficiently.

Ozium is fortified with propylene and triethylene glycols; kills germs nd odors for less than a cent for the average small room.

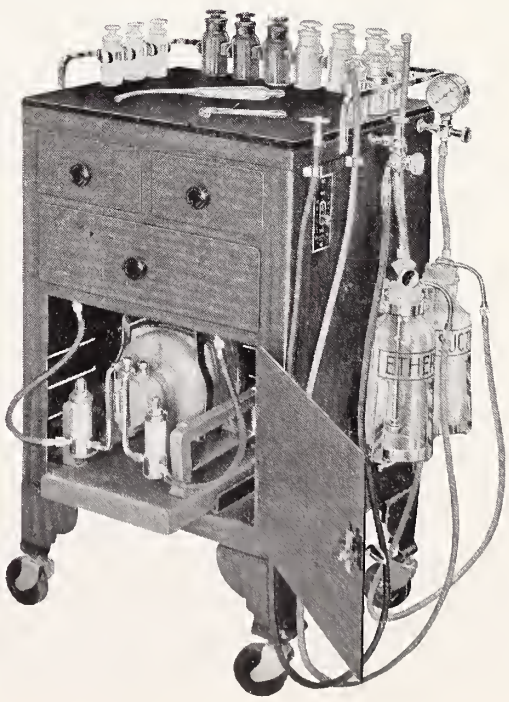
DE LUXE SET #1S-024 containing one Chrome-Plated Professional ispenser and 24 Ozium refills. $12.50.

OZIUM REFILLS #024 containing 24 Ozium "pressure-packed" refills. 3.00.

LK'S IDEAL

SUCTION AND PRESSURE TREATMENT UNIT

ne moderate price, and the maximum utility of this popular unit makes it tstanding as a piece of equipment for office or clinic use. The motor-compressor unit is rubber mounted—noiseless and vibrationless. Compressor is nnected direct to motor, with no belts or springs to rust, or to get out of justment. The motor unit is equipped with a carrying handle for portality. The Ralk's Ideal Unit is strongly and carefully built of the finest aterial; there is nothing to get out of order. Lubrication, only care required.



NEW MODEL WITH GLIDES INSTEAD OF CASTERS

No. 100-95 Without Ether Bottle.....$248
(White Enamel Cabinet)

No. 100-90 With Ether Bottle.....$268
(White Enamel Cabinet)
(Walnut or Mahogany color finish $12 extra)
Height 30¼" Width 18" Depth 15"

NEWS FROM WASHINGTON

Holger Nielsen Artificial Respiration Method Adopted Nationally

On recommendation of National Research Council, the Holger Nielsen push-pull method of artificial respiration has been adopted nationally and will supplant the Schafer prone-pressure method as soon as personnel can be taught the new system. Defense Department said the Holger Nielsen system, for years the standard method in Norway and Denmark, has been approved by virtually every national organization active in first aid work. Among them are the armed forces, American National Red Cross, U. S. Public Health Service, Federal Civil Defense Administration, Boy and Girl Scouts and American Medical Association's Council on Physical Medicine and Rehabilitation.

Experiments preceding selection of the system were carried on at Universities of Pennsylvania and Illinois, Springfield (Massachusetts) College and Harvard University. Experiments were performed on animals, on sick and injured patients who had stopped breathing, on human volunteers holding their breath, on freshly deceased cadavers and on volunteers whose breathing ability had been paralyzed for short periods of time by use of drugs. Reports on these experiments, and other studies and investigations, convinced National Research Council that the Nielsen method is to be preferred to all others as standard procedure in most cases. An important finding was that the Nielsen method exchanges about twice as much air as the Schafer method, up to now the standard artificial respiration technique with most organizations.

Under the Nielsen method the patient is placed face down, with either cheek resting on his crossed hands. The rescuer, kneeling at the patient's head, exerts pressure downward on the chest, then draws the arms forward to assist the patient's own "elastic recoil." With the Schafer method, the operator is not able to assist in the recoil. On this, Defense Department said, "When a victim is deeply asphyxiated and near death, there is a loss of natural muscle tone, less elasticity of the chest and less tendency for air to be sucked in. This makes the Schafer method least effective when most needed." Under special circumstances (arm injuries or when an individual cannot be placed on his stomach) other methods are recommended.

Report Cites Inadequacy of Sickness Insurance

Private insurance plans met only 10 per cent of costs of sickness—coverage of income loss as well as provisions for medical and hospital care—in 1950, according to statistical report just published by Social Security Administration. Nevertheless, this was again over 1949 (8.9 per cent) and 1948 (7.4 per cent). For medical care alone, 12 per cent of the nation's total bill was defrayed by insurance, compared with 10 per cent in previous year and 8 per cent in 1948. Conclusion drawn by SSA's Division of Research and Statistics, headed by I. S. Falk, is that "voluntary insurance is still meeting only relatively small parts of the need for insurance protection against the costs of illness in the United States." Report appears in December 1951 issue of *Social Security Bulletin.*

WSB Issues Regulations on Medical-Hospital Coverage

At a special press conference, Wage Stabilization Board issued General Wage Regulation 19 and Resolution 78, which set pattern for health and welfare plans that industry may provide for wage earners within framework of anti-inflation controls. Principal features are as follows:

1. Res.78 sets forth certain review criteria relating to temporary disability, hospital and surgical care, in-hospital medical care, life insurance and accidental death benefits. Proposed plans conforming to these citeria need only be reported to WSB and, after a 30 day waiting period, may be put into effect.

2. Proposals having benefit features that exceed criteria are subject to review by a tripartite health and welfare committee to be established and such plans may not be started without prior approval by WSB. For example, GWR 19 makes no provision for medical care in home or office. Such benefits are not automatically precluded but must be described in detail on reporting form and will be scrutinized by tripartite committee.

3. This committee, now in process of formation, will be an expert committee which will make its first report to WSB by March 30, 1952, and submit semi-annual reports thereafter. Final authority to approve or disapprove will rest with Board itself.

4. Industry-labor health and welfare plans in effect on or before January 25, 1951, or subsequently approved by WSB, do not require approval all over again. Nor do they even have to be reported again. However, any liberalization of benefits that is proposed from this time forward will have to be reported; if review criteria are exceeded, formal approval must be obtained. (Reporting forms are not ready yet.)

5. The term "plan" includes, but shall not be limited to, a health and welfare program provided through any of following: Insurance through a stock, mutual or cooperative insurance company; benefits provided through a prepayment organization; a self-insured plan administered by employer, employes, their representatives, a third party, or any combination thereof; any combination of such plans.

6. Proposed plans are approvable without reference to tripartite committee if ordinary hospital benefits are provided (semi-private accommodations, no special nursing, no "rest cures," etc.; if surgical fee schedules stay within Veterans Administration schedules and, in cash indemnity type plans, are compatible with limitations in standard commercial insurance contracts; if no provisions are made for dental care, cosmetic plastic surgery or major surgery performed in home or office; if in-hospital medical expenses do not exceed $5 daily or, if benefit payments are scaled downward after first visit or visits, $4 daily thereafter; if foregoing payments do not span a period in excess of 70 days.

7. Employers are permitted to pay up to 100 per cent of cost of coverage, with certain reservations.

WSB Getting Complaints on New Health Benefits Policy

Wage Stabilization Board regulations governing medical and hospital care benefits which wage earners may receive from employers have elicited numerous requests for clarification—and complaints. Particular target is the $200 ceiling on surgical expense. Probability is that WSB will amend its Resolution 78 to make its provisions clearer. For example, is maxillo-facial surgery performed by a dentist in a hospital an "unusual type of benefit?" Also, in areas where there is an appreciable difference between Veterans Administration fee schedules and those fixed by the prepaid surgical care plan, which one—if either—is applicable in labor industry contracts subject to government's anti-inflation controls?

VA Redefines Rules on Domiciliary Care and Insurance Recovery

Veterans Administration regulations, revised to conform with new laws, also redefine procedures for recovering medical care costs from insurance companies and for the first time set a dollar-and-cents standard for determining when a veteran has "no adequate means of support." The new regulations, printed in the *Federal Register* of November 30, include:

1. When a nonservice connected case applies for free domiciliary (not hospital) care, claiming "no adequate means of support," an income of $125 per month is the cutoff point for a man with no dependents. If income is under that, he is eligible; if above, he is not. However, if the patient is contributing in whole or in part to the support of a wife, child, mother or father, the $125 limitation does not apply.

Rules governing nonservice connected admissions to VA hospitals remain virtually unchanged. The veteran still must affirm he is unable to pay for hospitalization, and VA still may not investigate beyond the statement.

2. VA reaffirms its intention to recover money from obligated third parties for medical care rendered to veterans. This long standing policy has been enforced with varying success. It is aimed at collecting from health and hospital insurance companies, from union welfare funds, from public and private compensation funds, from legally liable persons (as in accident cases) and from other federal departments.

On this point, the regulation states that veterans "who it is believed may be entitled to hospital care or medical or surgical treatment or reimbursement for all or part of the cost, by reason of statutory, contracted or other relationships with third parties . . . will not be furnished hospital treatment without charge . . . to the extent of the amount for which third parties are liable."

The regulations explain in detail how hospital administrators are to proceed to make collections from such third parties.

Doctor Appealing Induction Loses Round, Keeps Battling

On December 28 the District of Columbia Court of Appeals denied a petition by Pvt. Stanley Orloff, M.D., that Army be enjoined from ordering him overseas pending disposition of his demand for a writ of habeas corpus. Likelihood is that Dr. Orloff, a New York psychiatrist who was inducted into Army last summer, will continue his fight from Korea to obtain his release, be permitted to practice medicine as an enlisted man or receive a commission in Army Medical Corps. His counsel asserts that his client is willing to accept a commission—a point still in conflict, as far as Army authorities are concerned—and that, in any case, Dr. Orloff is being dealt with unfairly and contrary to letter and spirit of doctor-draft law if he is permitted neither to practice his profession nor receive a discharge.

On December 17, the lower court in D. C. had held it lacked jurisdiction to act on habeas corpus petition. At that time, Dr. Orloff had completed medical technician training at Brooke Medical Center, Texas, and was under orders to report to Seattle for processing prior to embarkation for Korea. Army voluntarily extended his leave to December 29 and it was his motion for another extension that was rejected Friday by the appellate court. Inductee's lawyers may institute new proceedings in Seattle in order to gain decision before he is shipped out.

President's Commission on Health Announced at White House

On December 31, 1951 President Truman announced establishment of the President's Commission on the Health Needs of the Nation. Its chairman is Dr. Paul B. Magnuson, orthopedic surgeon and former chief medical director of Veterans Administration.

Commission has 15 members. Significant fact is that not one is a Federal official or employee. It is an expert group, comprising five M.D.'s, one dentist, one nurse, two PH.D.'s and authorities in fields of labor, education, agriculture and private philanthropy.

The members: Dr. Dean A. Clark, director, Massachusetts General Hospital; Dr. Joseph C. Hinsey, dean, Cornell Medical College; Dr. Gunnar Gundersen, trustee, AMA; Dr. Russel V. Lee, San Francisco physician; Dr. Evarts A. Graham, St. Louis surgeon; Marion W. Sheahan, R.N., director, National Committee for Improvement of Nursing Services; Dr. Ernest G. Sloman, president-elect, American Association of Dental Schools; Walter P. Reuther, president UAW-CIO; A. J. Hayes, president, International Association of Machinists; Clarence Poe, agricultural editor; Charles S. Johnson, president, Fisk University; Lowell J. Reed, vice-president, Johns Hopkins University; Chester E. Barnard, president, Rockefeller Foundation; Elizabeth S. Magee, secretary, National Consumers' League, and Dr. Magnuson.

President set up Commission by executive order, obviating delay and haggling that would have resulted had he requested Congressional action. Its single objective, he stated, is "to make a critical study of our total health requirements, both immediate and long term, and (will) recommend courses of action to meet these needs."

Commission's life will terminate in 12 months—earlier if its final report is submitted before next December. It will conduct public hearings, gather factual data and submit interim reports, culminating in final report with recommendations for action by U. S.

"Since we need the advice of all viewpoints, the Commission contains both professional and lay members," said President. "It will make a searching inquiry into the facts and give us the benefit of objective and constructive thinking on these problems which are of vital concern to every American."

Its jurisdictional scope is broad: Current and prospective supply of professional personnel . . . public health requirements . . . geographical distribution of resources and facilities . . . medical research . . . adequacy of private and public programs designed to provide methods of financing medical care.

Dr. Magnuson was out of city when President's announcement was made. It is presumed that Commission will have a full-time staff, with headquarters in Washington.

Two days after his appointment Dr. Gunderson, trustee of AMA, resigned stating "that the Commission is designed, both in its majority membership and in its objectives, as an instrument of practical politics to relieve President Truman from an embarrassing position as an unsuccessful advocate of compulsory health insurance."

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., C.P.H., Commissioner

PROCEDURES FOR PREVENTION OF RHEUMATIC FEVER BY PENICILLIN PROPHYLAXIS

While the cause of rheumatic fever is yet unknown, it is generally recognized that both the initial attack and the recurrences are usually preceded by an hemolytic streptococcus infection. Hence, attempts have been made to prevent rheumatic fever by controlling the hemolytic streptococcus infection with antibiotics. Two different methods have been used: (a) treatment of hemolytic streptococcus infection in the hope that, by suppressing the organism, the stimulus precipitating the rheumatic process be eliminated; (b) continuous administration of antibiotics to eradicate or suppress the streptococci and prevent implantation of new strains. Encouraging results having been reported, more systematic use of these measures of prophylaxis appears highly desirable.

TREATMENT OF HEMOLYTIC STREPTOCOCCAL INFECTION

Available evidence shows that treatment of streptococcus infection by sulfonamides does not prevent rheumatic initial attacks or recurrences. Recent studies in cases of respiratory infection with sore throat in which penicillin has been used indicate that prompt and adequate treatment prevents rheumatic fever in a significant number of cases. In one series of 978 individuals, only 2 definite and 3 possible cases of rheumatic fever have been observed, while in the control group of 996 patients there have been 28 definite and 7 possible cases.

No increase in antistreptolysin "O" titer is found in most of the treated cases, in contrast with the controls: an increase in titer is commonly found in patients who develop rheumatic fever. The lack of antibody production is taken as suggestive evidence that also substances precipitating the rheumatic process may be suppressed.

Treatment should be instituted promptly, if possible within 24 hours, hence, reports for laboratory procedures cannot be obtained before treatment is started. Typical cases of streptococcal sore throat are recognized clinically by the sudden onset of soreness with inflammation and exudate, rapid rise of temperature, swelling of regional lymph nodes and leukocytosis. However, atypical or subclinical infections are probably equally common: especially in patients who have been exposed to a known streptococcus infection or have a previous history of rheumatic fever or belong to a known rheumatic family, it is advised that therapy be tentatively instituted on reasonable suspicion.

If the fever does not respond to adequate treatment within 48 hours, streptococcal origin is unlikely and diagnosis and treatment should be reappraised. If, however, the disease responds to treatment, administration of penicillin should be continued although symptoms and signs may have disappeared, in order to avoid potentially dangerous relapses.

Different schedules of treatment have been proposed. Massell suggests the following routine:

First three days: Intramuscular procaine penicillin, 300,000 units once daily, or oral penicillin, 300,000 units four times daily.

Next two days: Oral penicillin, 300,000 units three times daily.

Next two days: Oral penicillin, 200,000 units three times daily.

Last three days: Oral penicillin, 100,000 units three times daily.

While there is good evidence sustaining the effectiveness of this procedure in preventing the occurrence of rheumatic fever, it should be clearly understood that experience is still limited. Different types of streptococcus may vary in their potency as precipitating agents of the rheumatic process; the dosage adopted may prove inadequate for some micro-organism; or there may be unavoidable delay in instituting the treatment. This may explain in part some unsatisfactory reports; also, the criteria for positive diagnosis of rheumatic fever adopted by some authors differ from those generally accepted. However, it should be recognized that it is current practice to administer penicillin for suspected cases of streptococcal sore throat. When the drug is pre-

scribed, and there is no valid reason to abandon this procedure, it is mandatory that the dosage be adequate in amount and duration. To avoid secondary infection, especially in known rheumatic cases, it would seem desirable to make every effort to eradicate the streptococcus from the environment of the patient.

CONTINUOUS ORAL ADMINISTRATION

Although the results justify the hope that the rheumatic disease may be prevented in most cases of hemolytic streptococcus infection, this procedure cannot be recommended for prophylaxis of recurrences in known cases of rheumatic fever. Probably one half of the attacks of streptococcus infection are so mild or atypical that they cannot be recognized or even suspected; however, a high percentage (40-50 per cent) of susceptible known rheumatic cases are stricken by a recurrence of the rheumatic process as a sequela of the streptococcal infection.

Continuous administration of sulfonamides is effective in suppressing the streptococcus in the oral flora of carriers, and in decreasing recurrences of rheumatic fever in susceptible patients. However, close supervision is necessary to avoid toxic effects; and sulfonamide resistant strains of streptococci are known to have developed in some cases.

Penicillin is also effective in eliminating the hemolytic streptococcus from the upper respiratory tract in the great majority of carriers. Continuous or repeated administration of the antibiotic has been shown to decrease the recurrences of rheumatic fever in series of cases carefully matched with comparable controls. The advantages of penicillin versus sulfonamides are: (1) no penicillin resistant strain of streptococcus have been reported to appear after prolonged use of penicillin in the amounts prescribed; (2) close supervision to avoid serious toxic effects is unnecessary. The disadvantages of this method of prevention are: (1) hypersensitivity to penicillin may develop; however, hypersensitivity is uncommon, especially with oral administration and in children, and rarely serious; if it does not develop in the first few days of administration, it is unlikely that it occurs later, especially if the administration is not interrupted; even if hypersensitivity should develop, it is known that it usually disappears after a short interval; (2) penicillin resistant strains of other organisms may develop and preclude the use of this antibiotic, if needed for treatment of other infections; as other antibiotics have become available, this danger has been greatly reduced.

Different schedules of administration have been adopted and at the present time it is impossible to decide which is the most effective and also the most economic and convenient. The following regime is advised by Massell: three 100,000 unit tablets daily, at least half an hour before or two hours after meals. This schedule should be followed throughout the year or at least through the months in which prevalence of streptococcus infection is highest. While there is no experience on the duration of this regime, it is probable that it should be continued for at least five years, especially in cases having had prolonged attacks or more than one episode of acute rheumatic fever. At current prices this procedure will cost about $100 per year.

PUBLIC HEALTH INFORMATION TO LAITY

Mortality for rheumatic fever and its sequelae has steadily decreased in the last fifty years, and it seems probable that morbidity is also declining; yet rheumatic fever with its sequelae causes more deaths at ages 5-14 than any other disease and is the most important chronic disease in this age group. Control of hemolytic streptococcus infections gives reasonable hope for a substantial reduction in the occurrence of rheumatic fever and rheumatic heart disease.

Physicians may have difficulty obtaining the cooperation of patients and their families in continuing expensive treatments when there is no evidence of active illness. The understanding cooperation of the parents is an essential element in the management of the rheumatic child, to avoid both unnecessary restrictions of activity and carelessness. The Connecticut Heart Association and the State Department of Health, working as they have been in close association and unity of purpose, propose to intensify their educational activity in this area, in cooperation with school administrators and other interested agencies, through dissemination of appropriate literature and talks at Parent-Teacher Association meetings and to other lay groups. It is hoped that this auxiliary program of public health information will help the physicians in the State in their work with rheumatic patients and especially in the application of these preventive procedures.

FROM OUR EXCHANGES

William F. Longmire et al *(Diseases of the Chest,* XIX.3) resected the auricular appendage for recurrent embolism in three cases of rheumatic heart disease with fibrillation. Cardiac function was not apparently influenced by the operative procedure. No evidence of further embolization has been noted over a following period of 5 to 10 months.

* * * *

In "Carcinoma of the Bladder—An Evaluation of Total Cystectomy and Other Methods of Treatment" *(N. E. Jour. Med.,* 244.14) Colby and Kerr report on 103 total cystectomies for cancer of the bladder performed at Massachusetts General Hospital from 1934 to 1950. Conclusion: Invasion of bladder muscle is an important feature of bladder tumors. Five year survival rate where muscle invasion existed was 10 per cent regardless of form of treatment. Cystectomy gave no better results than other methods in presence of muscle invasion.

* * * *

George E. Dark points out in "Notes on the Artificial Feeding of Infants" *(Jour. Maine Med. Assoc.* 42.1) that babies are born just as they were years ago, their physical makeup is just the same, their nutritional needs have not changed in the least, yet we have been seemingly less interested in accurate rules, axioms and practices of good feeding procedures. Much has been left to proprietary food manufacturers, depending on tables, charts and ingenious slide rule devices distributed by these same manufacturers.

* * * *

According to Frank L. Bryant, "Management of Recent Nasal Injuries," *(New Orleans Med. & Surg. Jour.* 103.8) a patient with an injured nose is initially concerned with the cosmetic result. The rhinologist, notwithstanding his desire to restore or even to improve the original contour, is primarily concerned with and interested in restoring nasal function. The author pleads for a systematic and careful examination in all injuries to the nose since an apparent slight blow can produce a fracture or dislocation, especially in younger individuals. Normal architecture (anatomy) is essential for normal function (physiology). A neglected nasal injury not infrequently leads to nasal occlusion with its resultant train of symptoms.

* * * *

In "The Treatment of Epilepsy," published in the *Journal of the Michigan State Medical Society,* (50.2) Frederic A. Gibbs furnishes an answer to the question, what is epilepsy? Detailed recommendations for treatment, both medical and surgical, are given. Future therapy in epilepsy will improve as new drugs and new surgical techniques are developed and interested physicians should watch for the latest information on these new developments.

* * * *

Jess E. Miller in "Renal Lethiasis: Prevention of Recurrence" *(Jour. of Okla. State Med. Assoc.,* 44.2) emphasizes the causative factors and preventive management as offering a greater challenge than removal, once calculi have formed.

* * * *

In *The Journal Lancet* (71.2) Dickman and Baronofsky in a paper entitled "Tracheotomy—One Solution for Pulmonary Problems in the Critically Ill Patient" report on series of 14 critically ill patients on whom tracheotomy was performed for other conditions than an acutely obstructed airway. In the authors' opinion this operation should be used wherever a patient cannot raise and expel intratracheal and bronchial secretions. It is preferable to employ tracheotomy before the need for it arises or at the earliest possible time following the onset of symptoms of retained secretions. The authors made use of the operation to clear obstructed airways of accumulated mucus and prevent terminal pneumonia.

* * * *

In *The Journal of the Maine Medical Association* (42.2) Champlin and Piper present a case report of gastrointestinal bleeding associated with hiatus hernia and point out that the symptoms of this entity may be confused with those of angina pectoris, biliary disease and peptic ulcer in stomach or duodenum. The case cited demonstrates many features of gall bladder disease, hiatus hernia with bleeding, and coronary artery disease.

Discussing "Major Trigeminal Neuralgia" in the *Journal of the Arkansas Medical Society* (47.10), Robert Watson brings out the fact that tic douloureux is a disease of middle and late life, since 85 per cent of those operated on for this painful condition are over 60 years of age. The true tic patient usually indicates with the fingertip the exact point of pain, hesitating actually to touch the sensitive spot for fear of actually producing the pain. This pain usually is intermittent. During the interval between attacks there are no abnormal sensations of the face, nor is there any abnormality of facial expression except the tendency between attacks to limit the use of the muscles of the affected side, lest abnormal muscle contraction again produce pain. The so-called trigger zone is usually a single localized area, stimulation of which is likely to produce pain. Neglect in caring for a certain area of the face often is the telltale indicator of a trigger zone. When masticating and swallowing food initiate attacks, severe nutritional damage may result. The treatment of tic douloureux is now completely standardized: viz, alcohol injection and section of the sensory nerve root. Every patient who undergoes surgery makes an irreversible bargain in that he exchanges the facial pain for loss of sensation over the previously painful area for the remainder of his life. The majority of surgically treated patients consider this a welcome exchange; however, some later become so annoyed by anesthesia and paresthesias that they consider the exchange price high. It is unfortunate that some of these patients are told that little can be done for their pain when nerve injection and surgery are available.

* * * *

Those interested in child health as it pertains to dental caries will find of interest "A Further Study of the Teeth of Five Year Old Children in Residential Homes (Orphanages) and Day Schools" by Mellanby and Mellanby *(Brit. Med. Jour.,* 4697). Over the five year period (1945-1950) in the groups surveyed the structure of the deciduous teeth was found to be not so good as that of the private school group, while their caries incidence was lower. Also in the orphans over the same period there had been improvement in the dental structure of almost 25 per cent and a decrease in caries from 10.5 to 7.2 per cent. The private school group showed comparatively good tooth structure in 1945 with no improvement five years later, and a relatively small decrease in caries from 1945 to 1950 (14.2 to 12.7 per cent). In answering the question, why these differences, it has been suggested that dietary discipline would tend to be more relaxed at certain periods in the case of the more prosperous children in their own homes, while those in orphanages would not be tempted with fads and fancies of diet. The latter would have regular meals of high nutritional and calcifying quality, including ample allowance of milk and a daily dose of cod liver oil which were found to be given routinely in orphanages. Apparently the children of the more prosperous get a better start with their teeth in utero and immediately after weaning; however, in the posteruptive stage routine dietary discipline in institutions seemingly pays dividends in promoting better teeth for this age group.

* * * *

James R. Wright in "Bronchoscopy in the Diagnosis of Bronchiogenic Carcinoma" *(North Carolina Med. Jour.,* 12.2) places the lung second only to the stomach as a site of primary cancer today. There is very little concrete evidence to support the claim that smoking is a causative factor. In the early stages there are few if any symptoms. In recent years a large number of cases have been discovered by routine chest films and through mass surveys for tuberculosis. Roentgenograms of the chest will usually show the lesion, even very early in the course of the disease. A positive diagnosis cannot be made from a chest film, however. When the lesion is in a small bronchus, bronchoscopic examination can be used to demonstrate the obstruction. Bronchoscopic examination also can be used for diagnosis if the growth is in a large bronchus where it can be visualized and a specimen removed for biopsy. Overholt has been able to see the tumor in 37 per cent of his cases and has obtained a positive biopsy in 34 per cent. Ochsner did a bronchoscopic examination in 125 out of 147 cases and obtained positive biopsies in 61 or 41.5 per cent. Cells in the sputum can be used for examination, though they are not so satisfactory as cells obtained by inspiration during bronchoscopic examination. The generally accepted treatment is surgical removal of the involved lung and hilar nodes. With this method of treatment about 20 per cent of the patients can be expected to survive five or more years.

* * * *

Kenneth S. Landauer, director of medical services of the National Foundation for Infantile Paralysis, conveniently summarizes the "Known Facts About Polio" in an article entitled "The Problems of

Medical Care of Poliomyelitis." (*Jour. Florida Med. Assoc.* 38.4.)

1. Polio is a common virus infection of human beings, without any evident extrahuman reservoir.

2. Polio may be caused by any one of three known polio viruses.

3. All the evidence points to the transmission of polio virus by close person to person contact. When polio afflicts one member of a household, the other members of the family are commonly found to be infected with the virus. There is no reliable evidence of transmission to humans by insects, water, food or sewage.

4. It is believed that the virus gains entrance to the digestive tract through the nose and mouth. The virus occasionally may travel directly up nerve pathways to invade the central nervous system.

5. The incubation period of the infection may be from 3 to 35 days. It is usually from 7 to 14 days.

6. The source of the infection is considered to be the secretions of the pharynx and the secretion of the bowels from infected persons, including patients. It is believed that the infected person is most likely to transmit the virus during the latter part of the incubation period and for a few days after the onset of the disease. While there is no evidence involving flies or sewage in the spread of the virus to human beings, it is still necessary to regard these factors as potential sources of infection.

7. Polio produces silent infection with resultant immunity in many. Manifest disease occurs in the few and presents a clinical spectrum from a minor illness to a rapidly paralytic death. Recent surveys indicate that about 80 per cent of the population over 15 years of age possess antibodies to one or more of the three known types of polio virus.

8. Polio is an ancient disease that has emerged in modern times in serious epidemic and paralytic form, and paradoxically in those countries with the highest material standards of living.

9. Peak incidence is in the 5 to 9 year age group, and 25 per cent of the cases are now over 15 years. Deferred exposure accounts for the disease occurring in the older age group. The older the patient the more severe are the consequences of infection. The infant provided with antibodies from the mother can during the period of passive immunity acquire an active lasting immunity without serious risk of paralytic disease. There seems to be little reason to hope that a curative agent for polio, when it is clinically manifest, will be found. The preparation of a vaccine has been difficult. Much labor and thought has gone into this phase of the research on polio. The problem has not been solved to the point where human experiments can be safely made. Dr. Landauer carefully avoids any commitments on such matters as producing passive and active immunity against polio. It is possible, however, to sense in the discussion his hope that in these fields lies the expectation of developing positive measures against the dread disease, poliomyelitis.

* * * *

Scientia Medica Italica is a new medical journal that we welcome to our column of exchanges. The new journal is published under the auspices of the High Commissariat for Hygiene and Public Health. It is planned as a "Quarterly Review of the Italian Contribution to the Development of Medicine and Biology." There is an English edition which makes the contents of the reviews easily available to the English reader. The two numbers that have been received are attractive in their format. The reviews are readable and important. The editorial board is made up from the faculties of medicine of all Italian universities. The contributors to the early numbers of this journal are recognized names in Italian medicine.

Italy in the past has made many important contributions to the progress of medicine. The language difficulty has served to obscure these contributions to most medical readers in Connecticut and it is with a feeling of pleasure that we welcome this journal which allows us to assign credit where it belongs. More important, however, than the mere matter of credit is the fact that *Scientia Medica Italica* makes easily available a whole new reservoir of clinical and scientific data.

* * * *

"The Importance of Hoarseness" is stressed by W. G. Kennon, Jr., in *Journal of the Tennessee State Medical Association* (44.10). Hoarseness is important because it is sometimes an early sign of carcinoma of the larynx. Carcinoma of the larynx is curable in its early stages. Patients and physicians often ignore this symptom. Dr. Kennon suggests that an examination of the larynx should be a part of every physical examination.

OBITUARY

Robert Corwin Sellew, Sr., M.D.

1875 - 1951



Robert Corwin Sellew, Sr., was born in Hillsdale, Massachusetts on February 12, 1875. He was educated in the local schools in that town and graduated from Yale Medical School in 1898. After a two year internship he opened practice in Springfield, Massachusetts, where he remained for one year. He then spent one year in practice in Great Barrington, Massachusetts, and eighteen years in practice in Mill River, Massachusetts, then moved to Canaan, Connecticut, where he remained in practice until his death on Memorial Day, 1951.

His professional ability and genial manner won for him a host of friends. He was always kindly and considerate of his patients' needs, and was ever ready to respond to their requests. He was a member of the staff of Fairview Hospital for many years, and was an honorary member at the time of his death. He was Medical Examiner and Health Officer of Canaan for many years. He was a member of the University Club of Litchfield County, the American Legion, the Masons, and the Litchfield County Medical Association.

He is survived by his widow, Harriet Sprout Sellew; one son, Robert C. Sellew, Jr., of Canaan, who is also a practicing physician in Canaan.

John R. Elliott, M.D.

Dr. Braceland Heads Board

The annual election of officers of the American Board of Psychiatry and Neurology took place at the December meeting of the Board in New York Ctiy when 275 candidates for certification in psychiatry and neurology were examined. The new president is Francis J. Braceland, psychiatrist-in-chief of the Institute of Living in Hartford. Bernard J. Alpers, professor of neurology at Jefferson Medical College, Philadelphia, is the new vice-president. David A. Boyd, professor of psychiatry in the Graduate School of the University of Minnesota and consultant to the Mayo Clinic, is the new secretary-treasurer. The Board will hold its next meeting in Chicago in June, 1952, at which time examinations of candidates will be conducted at the Neuropsychiatric Institute of the University of Illinois.

Latest Data on Status of Doctor-Draft Registrants

Selective Service figures show that as of November 30, 1951, the total of special registrants (physicians) in Priority I was 10,753. Major breakdowns, by classification: 2,871 on active military duty; 2,050 placed in 4-F; 2,677 in commissioned Reserve status; 1,609 deferred for essentiality; 109 deferred for reasons of dependency. There have been 11 deaths in Priority I group. Inductions remain at three. Corresponding data for Priority I dentists: 3,929 registered; 1,132 on active duty; 571 in 4-F; 1,060 in Reserve; 287 deferred for essentiality and 98 for dependency obligations. There has been only one induction and no deaths. In Priority II, physician registrants total 2,551, of whom 257 are in military service, 483 are in Reserve, 637 are in essential work and 405 in 4-F. Priority II dentists total 731. Serving in uniform are 141; 147 in Reserve; 80 are on essential list and 140 are deferred under 4-F. It is practically certain that there will be no call-up of draft-vulnerable physicians or dentists in February and a March call is improbable according to Gerald G. Gross, editor of *Washington Report on the Medical Sciences.*

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. F. Erwin Tracy, Middletown
President-Elect, Mrs. Barnett Freedman, New Haven
First Vice-President, Mrs. Ralph Ogden, West Hartford
Second Vice-President, Mrs. Dewey Katz, Hartford
Recording Secretary, Mrs. Arthur H. Jackson, Washington
Corresponding Secretary, Mrs. Harry C. Knight, Middletown
Treasurer, Mrs. William V. Wener, Norwich

State News

CIVILIAN DEFENSE

In this time of uncertainty the Woman's Auxiliary has the opportunity to take a leading role in the planning for Civilian Defense of our State. A four-point program from the national headquarters has been oultined:

1. A Home Warden Service, whereby women are asked to be responsible for certain elementary Civil Defense preparations within their own homes. Through this service women will be able to answer "yes" to these questions:

Have the women in your block made arrangements so that no child will be left screaming in the streets when the sirens sound?

Have you seen to it that no elderly people in your neighborhood would be left alone?

Do you know what to do in your own home when the siren sounds, and what you should have done before it sounded?

2. A Home Survey of Medical Supplies, so that where medical supplies are inadequate the use of Home Aid Kits, devised by the American Red Cross, could be sponsored.

3. Red Cross First Aid and Home Nursing Courses which are not only a must for all members of the Auxiliary, but for every woman in the community.

4. Nurse Recruitment Program which bears a close relationship with the Civilian Defense program.

There are also many skills existing in our organization. To find out what will be available in our State, each member should inform her county chairman of her qualifications in the event of an emergency.

Everyone should know the "Six Survival Secrets For Atomic Attack":

1. Try to get shielded.
2. Drop flat on the ground or floor.
3. Bury your face in your arms.
4. Don't rush outside right after a bombing.
5. Don't take chances with food or water in open containers.
6. Don't start rumors.

Mrs. Robert Tennant, Chairman

COMMITTEE MEETINGS

January 28—Board of Directors. YWCA, New Haven.

January 22—Revisions Committee. Mrs. N. Giles, chairman, Darien; Mrs. Daniel Samson, Thomaston; Mrs. William H. Horton, Winsted; Mrs. Barnett Freedman, New Haven; Mrs. Winfield E. Wight, Thomaston; Mrs. F. E. Tracy, ex officio, Middletown.

December 7—Nominating Committee. Mrs. Winfield Wight, chairman; Mrs. E. Roland Hill, Mystic; Mrs. Stevens J. Martin, Hartford; Mrs. Edwin Ottenheimer, Windham; Mrs. William Geer, Bridgeport.

December 5—*Today's Health*, luncheon meeting, Hotel Bond, in Hartford, for county chairmen.

Middlesex County is the first county to obtain its quota of subscription credits to *Today's Health*, in the annual contest conducted by the American Medical Association. Mrs. Joseph Epstein of Portland is chairman of this county's committee. Working with her are: Mrs. Raymond James, Essex; Mrs. Richard Grant, Cromwell; Mrs. Aldo Santiccioli, Middletown and Mrs. Archibald Thomson, Higganum.

SPECIAL NOTICES

SECTIONAL MEETING AMERICAN COLLEGE OF SURGEONS

A cordial invitation is extended to our readers to attend a two-day Sectional Meeting of the American College of Surgeons to be held at the Chalfonte-Haddon Hall in Atlantic City, New Jersey, on February 11 and 12.

Distinguished speakers will present papers, panels and symposia on current surgical problems and extensive programs for specialists in ophthalmology and otorhinolaryngology have been prepared for February 12. New surgical motion pictures will be shown, including several which were prepared especially for the Cine Clinics at the 1951 Clinical Congress, and also a stereoscopic colored film on Radical Resection for Carcinoma of the Stomach, which is attracting a great deal of attention wherever it is shown.

Dr. David B. Allman and his Committe on Arrangements have made extensive preparations to assure a good meeting and a warm welcome to Atlantic City for all visiting surgeons. Hotel accommodations may be obtained by writing to Mr. George J. Turcotte, Reservation Manager, Chalfone-Haddon Hall, Atlantic City, New Jersey.

RURAL HEALTH CONFERENCE TO STRESS SELF RELIANCE

Community self reliance in the development of health programs will be stressed at the seventh National Conference on Rural Health, to be held in the Shirley-Savoy Hotel, Denver, February 29 and March 1.

The two-day meeting will be sponsored by the Council on Rural Health of the American Medical Association in cooperation with national farm organizations. It will bring together medical, farm and education leaders from all over the country. The theme will be "Help Yourself to Health."

At a preliminary conference on February 28, "The Physician as a Citizen" will be the topic. The program of that meeting will be built around the doctor as a member of the community, interested in the economic and physical welfare of his neighbors.

Among the speakers of the main conference will be Dr. John W. Cline of San Francisco, president of the American Medical Association; Dr. F. S. Crockett of Lafayette, Ind., chairman of the Council on Rural Health; Robert Stearns, LL.D., of Boulder, Colo., president of the University of Colorado, and Allan B. Kline of Chicago, president of the American Farm Bureau Federation.

Also on the program will be Dr. A. C. Yoder, 84 year old physician of Goshen, Ind., who was elected the "General Practitioner of 1951" at the recent clinical session of the AMA in Los Angeles. Dr. Yoder still is in active practice after devoting more than a half century to the health and welfare of his rural community.

POSTGRADUATE COURSES ARRANGED BY THE AMERICAN COLLEGE OF PHYSICIANS

Spring 1952

Course No. 1—Gastro-Enterology (February 25-29, 1952) Stanford University School of Medicine and University of California Medical School, San Francisco, Calif. Co-Directors: Dwight L. Wilbur, M.D., F.A.C.P., Theodore L. Althausen, M.D., F.A.C.P. (Minimal Registration, 40; Maximal Registration, 100.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 2—Current Concepts of Allergy and Associated Disorders (March 3-7, 1952) Washington University School of Medicine, St. Louis, Mo. Harry L. Alexander, M.D., F.A.C.P., Director. (Minimal Registration, 25; Maximal Registration, 50.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 3—Diseases of the Blood Vessels. Diagnosis and Modern Treatment (March 10-15, 1952), Cornell University Medical College and The New York Hospital, New York, N. Y. Irving S. Wright, M.D., F.A.C.P., Director. (Minimal Registration, 25; Maximal Registration, 100.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 4—Clinical Medicine from the Hematologic Viewpoint (March 17-22, 1952), Ohio State University College of Medicine, Columbus, Ohio. Charles A. Doan, M.D., F.A.C.P., Director. (Minimal Registration, 50; Maximal Registration, 75.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 5—Internal Medicine (April 14-18, 1952), University of Michigan Medical School, Ann Arbor, Mich. Cyrus C. Sturgis, M.D., F.A.C.P., Director. (Minimal Registration, 30; Maximal Registration, 60.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 6—Electrocardiography: Basic Principles and Interpretation (May 12-17, 1952), Massachusetts General Hospital, Boston, Mass. Conger Williams, M.D., Director. (Maximal Registration, 25.) Fees: A.C.P. Members $60, Non-members $120.

Course No. 7—Trends and Newer Developments in Internal Medicine (May 12-16, 1952), Hahnemann Medical College and Hospital of Philadelphia, Philadelphia, Pa. Charles L. Brown, M.D., F.A.C.P., Director. (Minimal Registration, 30; Maximal Registration, 100.) Fees: A.C.P. Members $30, Non-members $60.

Course No. 8, Physiological Basis for Internal Medicine (June 2-7, 1952), University of Toronto Faculty of Medicine, Toronto, Ont., Can. Ray F. Farquharson, M.D., F.A.C.P., Director. (Minimal Registration, 25; Maximal Registration, 80.) Fees: A.C.P. Members $30, Non-members $60.

To register, write to The American College of Physicians, E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia 4, Pa.



now in parenteral form...

BANTHĪNE®

Bromide

Brand of Methantheline Bromide

for use when oral administration is difficult or impractical —when more prompt action is desired

Banthine—a true anticholinergic drug with an adequate range of safety—is now made available to the medical profession in parenteral form, for use intravenously or intramuscularly in those conditions characterized by nausea and vomiting, when oral medication cannot be retained and when a prompt action is desirable.

Through its anticholinergic effects, Banthine inhibits excess vagal stimulation and controls hypermotility.

In Peptic Ulcer —the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

In Pancreatitis —it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

In Visceral Spasm —it inhibits motility of the gastrointestinal and urinary tracts.

Parenteral BANTHĪNE is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference on Medical Service, now twelve years old by title, and twenty-five years old by organization, will hold its 1951 annual meeting at the Palmer House, Chicago, on Sunday, February 10, 1952.

Harlan English, M.D., Danville, Illinois, serves the Conference this year as chairman, and the Illinois State Medical Society acts as host.

The tentative program as its stands today (December 10, 1951) is as follows:

AMERICA'S NEXT SOCIAL AND HEALTH CRISIS

(1) "Care of the Aged with Chronic Diseases"

A. Size of the Problem—To be presented by an outstanding insurance actuary.

B. One Partial Solution—To be presented by a representative of a city welfare department.

LUNCHEON

Luncheon speaker: Hon. Everett McKinley Dirksen, U. S. Senator from Illinois, "Our Citizens and otheir Doctors."

(2) Veterans' Medicine.

A. "Future Implications of Veterans' Medical Care." George Craig, Past Commander of the American Legion.

B. "Unusual Problems in Veterans' Medical Care." Admiral Joel T. Boone, Chief Medical Officer, Veterans Administration, Washington, D. C.

C. "Hometown Veterans' Care—A Success or a Failure?"

Speaker to be announced.

The final program will be mailed to all who registered at the 1951 annual meeting as soon as the material is complete. In the meantime, we are submitting this preliminary material for your information and so that you can mark your calendar for the National Conference on Medical Service, The Palmer House, Chicago, Sunday, February 10, 1952.

THE FIFTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

Cincinnati, Ohio, March 31 through April 4

Sponsored by American Committee on Maternal Welfare. General meetings, panel discussions and symposia on: neonatal autopsies, sterility, complications of puerperium, Rh and Hr Sensitization, public health aspects of maternal care, dystocia, tomorrow's obstetrics, urinary incontinence, maternal mortality, lesions of the vulva, uterine carcinoma, obstetric hemorrhage, endometriosis, pregnancy complicating medical conditions, educational and social aspects of maternal care, ovarian tumors, toxemias, uterine bleedings, cesarean section, fetal wastage.

Register through American Committee on Maternal Welfare, Inc., 116 South Michigan Avenue, Chicago 3, Illinois.

SYMPOSIUM ON VD ADVANCES IS SCHEDULED FOR MAY 1-2

Annual symposium on advances in study of venereal diseases, cosponsored by American Venereal Disease Association and Experimental Therapeutics Study Section of National Institutes of Health, will be held in Washington May 1-2, 1952, it was announced recently. The deadline for receipt of titles of papers proposed for presentation at the meeting is January 15. These should be mailed, together with brief abstracts (maximum 200 words), to Dr. J. E. Moore, 804 Medical Arts Bldg., Baltimore 1, Md., and to Dr. William L. Fleming, 750 Harrison Avenue, Boston 18, Mass. Further information may be obtained from Dr. Frederick W. Appel, National Institutes of Health, Bethesda, Md., or Dr. Fleming.

YALE UNIVERSITY SCHOOL OF MEDICINE ANNOUNCES SPECIAL POSTGRADUATE COURSE

Diagnostic Medical Mycology

This course will be offered two afternoons a week for a period of three months. It will be open to a limited number of physicians and technicians who will be accepted on the basis of their training and experience in bacteriology and/or mycology. It will include instruction in laboratory procedures related to diagnostic medical mycology and the interpretation of laboratory findings. The student will work with those fungi included in the culture collection as well as those freshly isolated. Identification of these fungi will be undertaken on the basis of their cultural charactertistics and animal pathogenicity studies. To aid in this work there will be available a large pathology slide collection, a reprint collection, and a small mycology library. No lectures will be given, but informal discussions are planned. This course will be given under the supervision of the Department of Microbiology. Fee: $100.

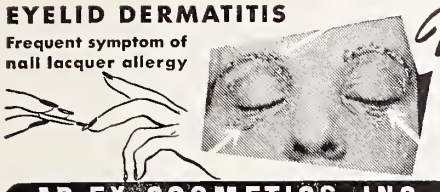
Enrollment may begin at any time by arrangement with the Office of the Assistant Dean in Charge of Postgraduate Education, L204 Sterling Hall of Medicine, 333 Cedar Street, New Haven, Connecticut.

Annual Meeting

Connecticut State Medical Society

Hartford, April 29, 30 and May 1

EYELID DERMATITIS
Frequent symptom of nail lacquer allergy



New AR-EX HYPO-ALLERGENIC NAIL POLISH
In clinical tests proved SAFE for 98% of women who could wear no other polish used.
At last, a nail polish for your allergic patients. In 7 lustrous shades. Send for clinical resume.



EXCLUSIVELY BY
AR-EX Cosmetics

AR-EX COSMETICS, INC. 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

Wanted Experienced Laboratory Technician, registered, for modern 200 bed hospital. Write Box No. 550, Bristol, Connecticut. Salary $300.

Approved interneships (rotating), and residencies in medicine and obstetrics-gynecology; and surgical residency approved only for training in preparation of surgical specialties; for July 1, 1952 or earlier; typical general hospital, modern, well-equipped; wide diversification of diseases; average patient census around 185; plenty of work; good recreational facilities, especially marine. Full-time radiologist, pathologist and anesthesiologist. Stipend for internes $1,200 per year and for residents $1,500-$1,800 per year, plus uniforms and maintenance. Class A medical school graduates only. The Lawrence and Memorial Associated Hospitals, New London, Conn.

Are you interested in being located in Bridgeport, Conn.? There is an active general medical practice including minor surgery, office and office equipment available to you. Attractive terms can be arranged. Address: Finkelstone & Finkelstone, Attorneys for Administratrix, 955 Main Street, Bridgeport, Conn.

NATIONAL ASSOCIATION MEDICAL DENTAL BUREAUS
Medicine Dentistry Science Business Health

OUR ETHICAL AND EFFICIENT COLLECTION SERVICE
IS MEETING THE APPROVAL OF MORE AND MORE
MEMBERS OF THE MEDICAL AND DENTAL
PROFESSIONS.

MEDICAL-DENTAL CREDIT BUREAU

EARL A. RILEY
EXECUTIVE MANAGER

"Where the business side of your practice receives professional attention"

189 STATE STREET BRIDGEPORT 3, CONN. PHONE 6-3813

OUR NEIGHBORS

New York

As a major experiment to improve public relations by collecting fees with graciousness, dignity and understanding . . . and yet with results . . . the new Bureau of Medical Economics of the Westchester County Medical Society has already proved to be an outstanding success. Collections have already amounted to more than $54,000 from over 7,000 accounts. Originally subsidized by the Society for a two year period the Bureau is already operating in the black after only one year. While many of the cases started off with violent antagonism to the medical profession not one has had to be referred to the grievance committee of the Society for action. In each case, the doctor, the patient and a staff member of the Westchester Medical Society has been able to iron out the matter.

The first director of Columbia University's new Institute of Administrative Medicine is Dr. E. Dwight Barnett, for the past five years director of Harper Hospital, Detroit. Prior to 1946 Dr. Barnett was a director of school health in his native city, Santa Rosa, California, and a director of health and hospitals in Sonoma, California.

The Institute began operations in January this year. It is the first in the United States to offer an advanced degree in administrative medicine and will conduct research in all phases of health administration.

NEWS
from County Associations

Fairfield

Frank J. Wales of Monroe died at the Danbury Hospital on December 14, 1951. Dr. Wales was medical examiner for Monroe for 40 years and health officer at the same time for a shorter period. He was president of Fairfield County Medical Association in 1946 and represented Monroe in the General Assembly in 1904.

Ralph J. Lenoci of Bridgeport has closed his office to pursue a course of study in surgery at the Boston City Hospital for the next two and one half years. Following this Dr. Lenoci plans to return to Bridgeport to resume practice.

The Stamford Academy of General Practice is sponsoring a Post Graduate Course on Diseases of Metabolism and Endocrinology to be held in the Stamford Hospital auditorium, given by the Yale University School of Medicine. The course began on January 22 when Dr. C. N. H. Long, dean of the Yale Medical School, presented the first conference on "Pituitary Adrenal Axis." Dr. J. P. Peters, John Slade Ely professor of medicine will present conferences on "Diabetes Mellitus" and "Edema," Dr. D. M. Kydd will hold a conference on "Thyroid Physiology" and Dr. Klatskin, on "Liver Function in Health and Disease." Dr. L. Welt will present a paper on "Lower Nephron Nephrosis." The course will be completed in April.

William Kaufman of Brildgeport read a paper at the January Psychosomatic Forum held at Bellevue Hospital under the auspices of the American Psychosomatic Society and the American Psychoanalytic Association.

The Bridgeport Medical Association held its annual banquet at the Algonquin Club in Bridgeport on the night of January 15. The Banquet Committee, consisting of Joe Watts, Bill Curley, Jr., and Nick Creaturo, did their usual good planning leading to an enjoyable evening. Officers installed were as President, Mark Gildea; Vice-President, John Nolan; President-elect, Owen Groark; Secretary, Joseph Hennessey and Treasurer, Albert Levenson.

Members of the Fairfield County Medical Association have been mailed a questionnaire giving them an opportunity to express their interest and desire to serve on the various committees of the state and county organizations. Results of this poll will be furnished the councilor, Dr. Parmelee, to the Council of the State Society at the time of nominations of these committees.

Hartford

Benjamin V. White of Hartford participated in a panel on "Periodic Health Examinations" at the 12th Annual Congress on Industrial Health held in Pittsburgh in January.

Charles W. Goff, assistant clinical professor of orthopedic surgery at Yale University School of Medicine, presented a paper on "Growth Deter-

from among
all antibiotics,
Neurologists and Neurosurgeons
often choose

AUREOMYCIN

because

It readily passes into the cerebrospinal fluid, the presence of meningitis making little difference in its concentration.

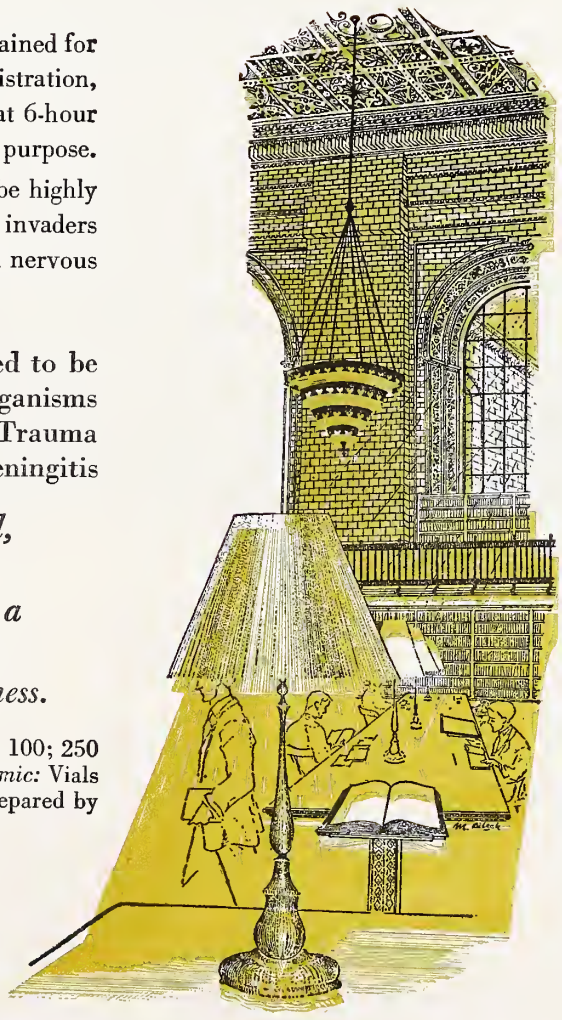
Measurable serum levels are maintained for as long as 12 hours after oral administration, oral doses of 5 to 10 mg. per kilo at 6-hour intervals being adequate for this purpose.

Aureomycin has been shown to be highly effective against those bacterial invaders commonly encountered in central nervous system infections.

Aureomycin has been reported to be effective against susceptible organisms in: Brain Abscess • Cranial Trauma Infection • Encephalitis • Meningitis

Throughout the world,
as in the United States,
aureomycin is recognized as a
broad spectrum antibiotic
of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.



LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, N.Y.

minations for the Physician" before the Society for Research in Child Development at Philadelphia on December 27, 1951. In his paper, Dr. Goff presented the problem of growth influences operating in orthopedic disorders and informed his audience that the Newington Home for Crippled Children affords the physicians of Connecticut the opportunity of acquiring a working acquaintance with growth determinations and their meaningfulness in respect to diseases and disorders. Attention is called to the results of these growth influences and to the fact that more centers are needed to serve the physicians of each community.

William H. Pomeroy of Poquonock has been elected president of the Hartford Chapter, American Academy of General Practitioners.

New Haven

Max G. Carter of New Haven is the author of a case report entitled "Cardiac Arrest: Complete Recovery After Twenty-Five Minutes," published in *J. A. M. A.* 147:14 (December 1, 1951).

Harold Sears Arnold of Woodbridge, former instructor in the Yale University School of Medicine and a member of the University's Department of Health since its establishment, died in New Haven Hospital on December 21, 1951. Dr. Arnold had practised medicine in New Haven for over 40 years.

Arthur F. Thompson, retired general practitioner, died at his home in New Haven on December 30, 1951 following a long illness.

Middlesex

Norman Gardner attended the Clinical Session of the American Medical Association in Los Angeles in December.

News from Yale University School of Medicine

Dr. Frederick H. Theodore, assistant clinical professor of ophthalmology, Post-Graduate Medical School, New York University, Bellevue Medical Center; assistant ophthalmic surgeon, Manhattan Eye, Ear and Throat Hospital, adjunct ophthalmic surgeon, Mount Sinai Hospital, was guest lecturer on December 15, 1951, at the Yale University School of Medicine Post-Graduate Courses in Ophthalmology. His subject was "Allergic Conjunctivitis." The lecture was followed by Kodachrome pictures illustrating the different types and a brief discussion of the treatment was given.

The meeting was preceded by discussion of two clinical cases: (1) A thirteen year old white male with huge "cobblestone" palpebral eyes with an unconfirmed diagnosis of vernal conjunctivitis. Scrapings have been negative for eosiniphils; there is little itching and response to all medication including local cortisone has been poor. Systemic cortisone will be tried. (2) A fifty-seven year old male, a known diabetic and borderline hypertensive with a five week febrile course unyielding to all antibiotic treatment and showing a blind, non painful eye with chronic uveitis, detachment and exophthalmus and poor visulation of the fundus. He was presented because of questionable nodules in the liver. The question of a malignant melanoma or liver abscess was the serious differential diagnosis. Transillumination was not helpful.

The Department of Psychiatry and Mental Hygiene of Yale University has announced the appointment of Dr. Francis J. Braceland as clinical professor of psychiatry; Dr. Jules V. Coleman and Dr. William L. Pious have been appointed associate clinical professors of psychiatry, while Dr. Else Pappenheim has been named assistant clinical professor of psychiatry.

NEW BOOKS IN REVIEW

THE BATTLE FOR MENTAL HEALTH. By James Clark Moloney, M.D. *Philosophical Library, Inc.: New York.* 105 pp. $3.50.

Reviewed by Herbert Thoms

This book is a protest against regimentation in obstetrical, pediatric, and child-rearing methods in our culture, and the substitution of more permissive procedures in these fields. Mental health is innate in the newborn and "the effects of a bad start may be perpetuated throughout the life of the individual, a fact of the most stupendous importance which is gradually becoming evident to more and more people." Dr. Moloney sees in training for childbirth and rooming-in procedures high importance in the parent-child relationship and he leaves no uncertainty as to his opinion of some of the present conventional practices, as for example:

"Perhaps the infant is merely caught in the web of the obstetricians' efficiency, their unconscious conspiracy with

Cortone®

Safety in the Prolonged Control of RHEUMATOID ARTHRITIS



Successful clinical experience with CORTONE in many *large series* of patients reveals the safety of this product. The administration of CORTONE does not necessitate any measures that are not readily available to the physician in everyday practice. The use of simple laboratory tests (sedimentation rate, urinalysis, blood count, blood pressure, and recordings of weight), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

One investigator notes: "We have not been impressed by the severity or frequency of side-effects . . . The side-effects due to excessive adrenal cortical hormone disappeared when the hormonal agent was discontinued."

NORCROSS, B. M., *N. Y. State J. Med.* **51**: 2356, Oct. 15, 1951.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

Cortone®
ACETATE
(CORTISONE Acetate Merck)

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

maternity and nursery nurses, their unconscious collusion with the hospital management. Be that as it may, as a group these professionals bitterly resist change. Theirs is the responsibility for the spread of the death-dealing epidemics of infant diarrhea. The mother whose baby has died of this disease in the central nursery can point her accusing finger at the hospital managmeent and at her obstetrician. Her child's death could have been avoided. Diarrhea of the newborn is not encountered when the primary unit (mother and baby) utilizes rooming-in."

Dr. Moloney supports his opinions with many scientific clinical and anthropological observations and as a psychiatrist, on the side lines, so to speak, of obstetrical and pediatric care he maintains an objective viewpoint in which he is highly convincing. To this reviewer the book will have its chief value for obstetricians and pediatricians who wish to be informed of recent thinking of parent-child relationships in our culture and their own responsibilities as physicians. This book is militant; it is also timely, a combination which should give it the high potential value which it deserves.

PSYCHSOMATIC GYNECOLOGY INCLUDING PROBLEMS OF OBSTETRICAL CARE. By William S. Kroger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; Attending Obstetrician and Gynecologist, Edgewater Hospital, Chicago and *S. Charles Freed*, M.D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. *Philadelphia*: W. B. Saunders Co. 1951. 503 pp.

Reviewed by STANLEY B. WELD

In this volume the authors apparently have attempted to present the practical aspects of the relationships between physical and emotional process as they affect the female reproductive organs. At the same time the interrelationship between gynecology, obstetrics and endocrinology on the one hand and psychiatry on the other is delineated. It is remarkable how many pages can be written on subjects little heard of a few decades ago. Much of the material in this volume is in the field of speculation, but the rapid development in the psychosomatic approach to disease in recent years lends importance to many of the views herein expressed. True, there is considerable repetition and many times a prolixity which becomes tiresome, but after reading the entire volume one is impressed with the sincerity of the authors and credits them with emphasizing means of diagnoses and methods of therapy which the gynecologist and obstetrician will do well to heed. To the gynecologist with psychiatric training much of this is old stuff dressed up for this age of psychosomatic medicine.

Many of the authors' credos will not be acceptable to all physicians, even though they are supported by an exhaustive bibliography. For example, it will be difficult for many obstetricians to subscribe to the old belief revived that maternal emotional attitudes actually influence the structure of the fetus. The authors' belief that nausea and vomiting of pregnancy is of psychogenic origin will be difficult for many to accept. This influence of the psyche reaches a new high in the chapter on "Emotional Spontaneous Abortion."

Breast feeding and the rooming-in plan of post partum care are well discussed early in the volume. Grantly Dick Read has contributed a chapter entitled "Psychosomatic Aspects of Pregnancy" which covers the various facets of natural childbirth. This is followed by a chapter by the authors on " 'Suggestive Relaxation' or Hypnoses in Labor" in which this method of treatment is compared with the Read method. Obstetricians should find this very interesting reading.

The discussions on sterility, frigidity, dyspareunia, low backache, and pelvic pain are good but offer little that is new. They serve rather to emphasize to the physician that one must not overlook the psyche when considering the soma. The chapter on obesity brings out a fact often overlooked, viz., that this results from emotional disturbances in many instances and is best approached with that in mind. The closing chapter on such disorders as pruritus vulvae, homosexuality, retroversion, prolapse, and congestion-fibrosis syndrome are up to date with references to Taylor's recent work and Kinsey's study of sex practices in the female.

The volume is well printed, very legible, and contains many examples illustrating the text. It makes tiresome reading for long at a time but should be used by gynecologists and obstetricians as a reference book, even though the reader may not agree with all the views expressed.

THE 1951 YEAR BOOK OF RADIOLOGY. By Fred Jenner Hodges, M.D., *John F. Holt*, M.D., University of Michigan; *Harold W. Jacox*, M.D., and *Vincent P. Collins*, M.D., Columbia University. *Chicago: The Year Book Publishers, Inc.* 1951. 373 pp. with illustrations. $7.

Reviewed by WENDELL C. HALL

The 1951 Year Book of Radiology, as in previous years, is divided into diagnostic and therapeutic sections, although the therapeutic section is somewhat smaller than in past years. Approximately 350 articles are reviewed, somewhat more than half of them in the diagnostic section. These articles were taken from many medical journals and almost one third of them from European and South American journals. There are more than 200 illustrations, and comments beneath the illustrations add materially to their value. The book in printed on a very good grade of glossy paper which undoubtedly contributes considerably to the high quality of the illustrations. No startling advances have been reported in the radiological literature during the past year alhough it is of interest to note that an article is reviewed in the diagnostic section in which carotid body tumors are accurately diagnosed by angiocardiography.

Dr. Harold W. Jacox and Dr. Vincent P. Collins are new editors of the therapeutic section and they maintain the usual high standards of previous years.



control companion to ACTH and CORTISONE

"In clinical practice it is clearly wise to test the urine of both diabetic and non-diabetic patients for sugar at intervals during administration of cortisone or ACTH and to carry out appropriate investigations and treatment if glycosuria occurs. Particular caution is necessary for diabetic patients."

Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

To avoid such clinical surprises and simplify clinical control, ACTH and cortisone therapy is profitably *preceded, accompanied* and *followed* by routine testing for urine-sugar. *Clinitest* Reagent Tablets provide a rapid, reliable and convenient method—easily used by both physician and patient.

CLINITEST *for detection of urine-sugar*

BRAND • REG. U. S. PAT. OFF.

REAGENT TABLETS



You can assure regular, reliable urine-sugar analyses by prescribing the Universal Model Set (No. 2155). Available at all pharmacies at $1.50.

AMES COMPANY, INC.
ELKHART, INDIANA
Ames Company of Canada, Ltd., Toronto

C-2

CHARTER AND BY-LAWS — CONNECTICUT STATE MEDICAL SOCIETY

The Connecticut State Medical Society was incorporated by the General Assembly of the State of Connecticut in May 1792 and its Charter has been amended from time to time by legislative action at the behest of the Society. The first meeting of the Society was held in Middletown on October 9, 1792.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suits of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismission and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all monies and other property belonging to the corporation in such manner as ti may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnane to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of the Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society, (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with the Connecticut State Medical Society and (3) the members of the Council of the Society.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held upon such day in each year as The House of Delegates shall, from time to time, prescribe. Notice of such annual meeting date shall be sent to every affiliated county medical association at least sixty days before each annual meeting date so prescribed.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in The House of Delegates of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in The House of Delegates, one Councilor from each affiliated county medical association. The Councilors holding office at the time of the passage of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham, and Middlesex shall each elect one Councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one Councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a Councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state, shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

BY-LAWS

ARTICLE I

Name

Section 1 Name

Par. 1. The name of this organization shall be The Connecticut State Medical Society.

ARTICLE II

Purposes

Section 1. Purposes

Par. 1. The purpose of this Society shall be to federate and bring into one organization the medical profession of the State of Connecticut; to unite with similar societies in other states to form the American Medical Association; to extend medical knowledge and advance medical science, to elevate the standards of medical education, and to promote friendly intercourse among the physicians, to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never be maintained and conducted for the pecuniary profit of its members, officers, or employees but shall be, and remain, a strictly scientific and educational corporation, and no mem-

THE MONOGRAPH SERIES ON SCHIZOPHRENIA

No. 3—PSYCHOTHERAPY WITH SCHIZOPHRENICS

Edited by

EUGENE B. BRODY and FREDRICK C. REDLICH

Introduction by ROBERT P. KNIGHT

A Symposium sponsored by the Psychiatric Department of Yale University Medical School, with contributions by Jacob A. Arlow, Robert C. Bak, Eugene B. Brody, Ludwig Eidelberg, K. R. Eissler, Jerome D. Frank, Frieda Fromm-Reichmann, Lawrence S. Kubie, Ruth W. Lidz and Theodore Lidz, Fredrick C. Redlich, Elvin V. Semrad, Milton Wexler, David Wright.

$4.00

Previously published

No. 1—DEMENTIA PRAECOX OR THE GROUP OF SCHIZOPHRENIA

By PROFESSOR EUGEN BLEULER

Translated by JOSEPH ZINKIN, M.D.

Foreword by NOLAN D. C. LEWIS, M.D.

This classic text of psychiatry has hithertofore not been available in English

$7.50

No. 2—SYMBOLIC REALIZATION: A NEW METHOD OF PSYCHOTHERAPY APPLIED TO A CASE OF SCHIZOPHRENIA

By M. A. SECHEHAYE

"On reading the account of the discovery of a new method, which led to a remarkable therapeutic success, one is struck by the author's perseverance, her devotion to her patient, her frank objectivity, and particularly by her ability to let the reader participate not only in the progress of the actual work but also in the living experience which she and her patient shared."

$3.25

INTERNATIONAL UNIVERSITIES PRESS, Inc.
227 West 13 Street, New York 11, N. Y.

Please send the books checked:

THE MONOGRAPH SERIES ON SCHIZOPHRENIA
No. 1 ☐ No. 2 ☐ No. 3 ☐

☐ Remittance enclosed. ☐ Send C.O.D.

Name .....
Please print carefully

Street .....

City..... Zone..... State.....

☐ Send your free catalogue. CSMJ

Sealy announces . . . a new professional discount on the

Sealy FIRM-O-REST POSTUREPEDIC

Innerspring Mattress



The undisputed leadership of the Sealy Firm-O-Rest Posturepedic mattress in its field has, we believe, special significance for members of the medical profession. Every week, hundreds more of *your* patients become *our* customers . . . motivated by a growing preference for a firmer, more resilient mattress, a preference the profession has done much to create. In order to acquaint physicians everywhere with the unique and exclusive features of the first mattress to be designed in cooperation with leading orthopedic surgeons, Sealy is establishing a special professional discount on the purchase of the Sealy Firm-O-Rest Posturepedic Mattress for the doctor's personal use only. Now . . . at a substantial saving . . . doctors can discover for themselves the luxurious comfort and the spine-on-a-line support that have merited for the Sealy Firm-O-Rest Posturepedic acceptance for advertising in the Journals of the American Medical Association. Your Sealy dealer will be pleased to accommodate you.

SLEEPING ON A Sealy IS LIKE SLEEPING ON A CLOUD!

ADVERTISED IN AMERICAN MEDICAL ASSOCIATION PUBLICATIONS



Reprints of these helpful booklets now available, FREE. Sealy will be happy to forward you a quantity for use in your office of THE ORTHOPEDIC SURGEON LOOKS AT YOUR MATTRESS, *and* A SURGEON LOOKS AT YOUR CHILD'S MATTRESS, *by J. R. Garner, M.D. Fellow of the AMA. Brief, instructive, they'll interest your patients. Simply fill in the attached coupon below.*

SEALY MATTRESS COMPANY
79 Benedict St., Waterbury 89, Conn.

Gentlemen: Please send me without charge:
_____Copies of "The Orthopedic Surgeon Looks at Your Mattress"
_____Copies of "A Surgeon Looks at Your Child's Mattress"
_____Please send free information on professional discount

NAME_____

ADDRESS_____

CITY_____ ZONE_____ STATE_____

ber, officer or employee of the Society shall at any time receive or be entitled to receive any pecuniary profit from the operation of the Society except a reasonable compensation for services actually rendered.

ARTICLE III

Ethics

Section 1. Ethics

Par. 1. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

ARTICLE IV

Component Associations

Section 1. Component Associations

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

ARTICLE V

Membership

Section 1. Membership

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

Section 2. Members

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

Section 3. Student Members

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medisine in an acceptable medical school, as provided in Section 478f of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of this Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

Section 4. Associate Members

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the right and privileges of the Society except that they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

Section 5. Honorary Members

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 4. They shall be accorded the privilege of participating in scientific work.

ARTICLE VI

Officers

Section 1. Officers

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Editor-in-Chief of the Journal, the Literary Editor of the Journal, a Speaker of the House of Delegates, a Vice-Speaker of the House of Delegates, the elected delegates to the American Medical Association, and a Councilor elected from each component association.

Par. 2. The officers, except the President and the Councilors, shall be nominated by the Nominating Committee and elected annually by ballot by the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham, and Middlesex counties in the odd numbered years.

Par. 5. A Councilor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even numbered years.

Par. 6. No Councilor elected by a county association shall serve more than three successive terms of two years each, but after a lapse of one term of two years such Councilor may be eligible for re-election.

Par. 7. Any vacancy in the office of Councilor shall be filled by the county association in which the vacancy occurs.

Section 2. Duties of Officers

Par. 1. The President shall preside at meetings of the Society, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties and in the absence of the President or upon his request shall assume the duties of the office. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the term by the First Vice-President. In the event of a vacancy in the office of President-Elect, the First Vice-President shall succeed to that office and the office of First Vice-President shall be assumed by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the JOURNAL prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Editor-in-Chief of the JOURNAL, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the JOURNAL by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

Par. 7. The Literary Editor of the JOURNAL with the guidance and counsel of the Editor-in-Chief and the Editorial Board, shall be responsible for the literary and scientific content of the JOURNAL and its editorial policy.

Par. 8. The Speaker of the House of Delegates shall preside at all regular and special meetings of the House of Delegates except at such times as he may request the Vice-Speaker to preside during his temporary absence from the Chair. He shall cooperate with the Executive Secretary and other officers of the Society in arranging the agenda for meetings of the House of Delegates and he shall appoint reference committees as provided in Article VII and VIII of the By-Laws, or as he may be directed by vote of the House. The Speaker of the House shall have the privilege of voting in the House of Delegates for the purpose of breaking a tie, and, he may meet with the Council, without privilege of voting, upon invitation of the Chairman of the Council, for the purpose of discussing procedure in the House of Delegates.

Par. 9. The Vice-Speaker of the House of Delegates shall assist the Speaker of the House of Delegates in the discharge of his duties and in the absence of the Speaker, or upon his request, shall assume the duties of his office. In the event a vacancy occurs in the office of Speaker of the House of Delegates, the Vice-Speaker shall succeed to that office until the next annual meeting of the Society.

Par. 10. In the event of a vacancy in the office of Executive Secretary, Treasurer, Editor-in-Chief of the JOURNAL, Literary Editor of the JOURNAL, Vice--Speaker of the House of Delegates, the vacancy shall be filled by a member of the Society appointed by the Council to serve until the next annual or semi-annual meeting of the House of Delegates.

ARTICLE VII

MEETINGS

Section 1. Annual Meetings

Par. 1. The Society shall hold an Annual Session during which there shall be held scientific meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

Section 2. Special Meetings

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Section 3. Recommendations

Par. 1. Recommendations made by any scientific session or section meeting may be submitted to the House of Delegates.

Section 4

Par. 1. All resolutions to be introduced before the House of Delegates at an annual, semi-annual or special meeting, except resolutions and recommendations from the Council and resolutions and recommendations that may be contained in committee reports, shall be delivered to the Executive Secretary in time for publication in the official agenda for the meeting at which action is to be taken.

Par. 2. Resolutions and recommendations to be introduced before the House of Delegates at an annual, semi-annual or special meeting by the Council or resolutions and recommendations that may be contained in reports of standing or special committees of the Society shall be published in the official agenda for the meeting at which action is to be taken. The official agenda shall be distributed to the members of the House of Delegates at the earliest possible date preceding the meeting.

Par. 3. Resolutions and recommendations which do not meet the requirements of Paragraphs 1 and 2, of Section 4 of this article may be accepted for action by a session of the House of Delegates by a majority vote of the delegates present. Such resolutions and recommendations shall be referred at once by the presiding officer to reference committees appointed by him from the membership of the House. These reference committees shall consider the resolutions and recommendations referred to them and shall report, with recommendations, to the House before adjournment of the session.

ARTICLE VIII

House of Delegates

Section 1. House of Delegates

Par. 1. The House of Delegates shall be the legislative and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist of the delegates elected by the component county associations and the members of the Council.

Par 2. Each component association shall be entitled to send to the House of Delegates each year one delegate for every thirty-five members or any additional part of that number A component county association with less than thirty-five members shall be entitled to one elected member of the House of Delegates.

Par. 3. The presiding officer of the House of Delegates may, in his discretion, appoint committees, to be known as reference committees, from the membership of the House to which business or reports presented before the House may be referred for review and recommendations.

Section 2. Duties

Par. 1. The House of Delegates shall elect delegates and alternate delegates from the Society to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body. These delegates and alternates shall take office on the first of January following their election and shall serve terms of two years.

Par. 2. The House of Delegates shall have authority to appoint committees for special purposes from among the members of the Society. Such committees shall make written reports through the Council to the House of Delegates, and members of these committees may attend meetings of the House of Delegates and participate in the discussion of reports submitted by them.

Par. 3. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections.

Par. 4. No memorial or resolution shall be issued in the name of the Society without first having been approved by the House of Delegates.

Section 3. Meetings

Par. 1. The Annual Meeting of the House of Delegates shall be called by the Council and shall be held during the week of the Annual Session of the Society. The order of business shall be arranged as a separate section of the program by the Council.

Par. 2. A Semi-Annual Meeting shall be held when required at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quorum.

ARTICLE IX

The Council

Section 1. Membership

Par. 1. The Council shall consist of one Councilor from each county association and the President, the President-Elect, the Executive Secretary, the Treasurer, the Editor-in-Chief of the Journal, the Literary Editor of the Journal, the delegates to the American Medical Association, any member of the Society who is currently serving as an officer of the American Medical Association, as provided in Article VII, Section 1, of the Constitution of the American Medical Association, and a Councilor-at-large, when elected by the House of Delegates as provided in Paragraphs 2 and 3 of this section.

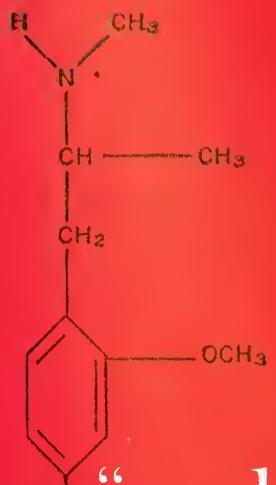
Par 2. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election to the Council for a term of one year of any member of the Society who is serving as a general officer of the American Medical Association as defined in Article VII, Section 1, of the Constitution of that Association.

Par. 3. The Council may, in its discretion, recommend to the House of Delegates, at any annual meeting, the election of a Councilor-at-large, who shall serve for a term of one year. Any member of the Society shall be eligible for nomination to the office of Councilor-at-large.

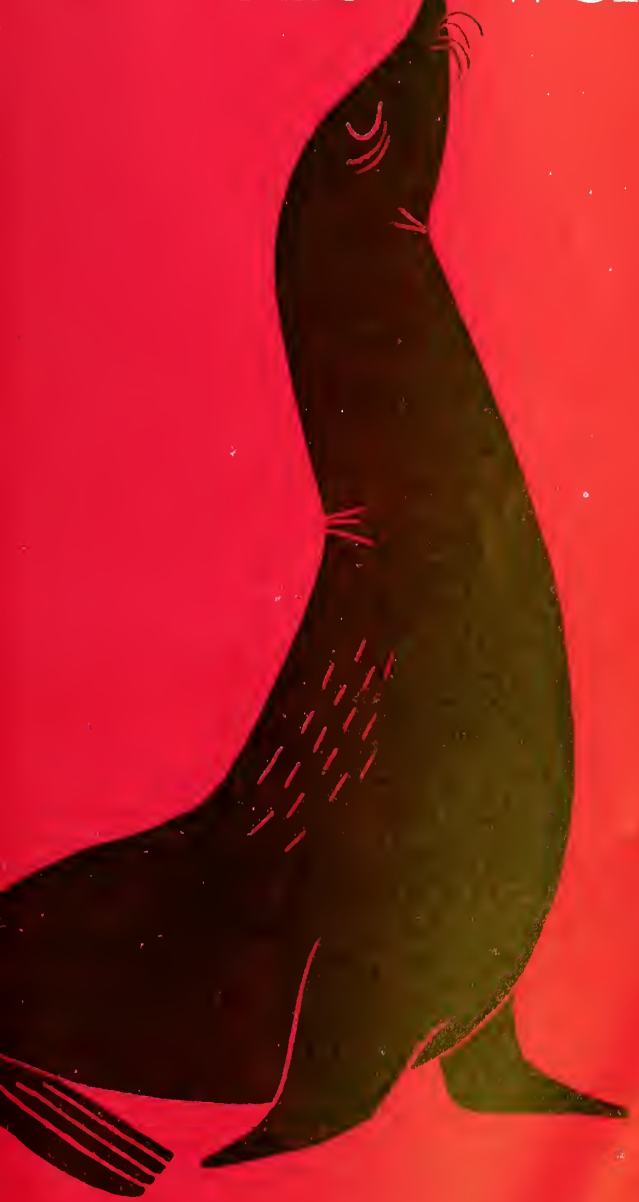
Section 2. Meetings

Par. 1. The Council shall meet at least every two months throughout the year, except during the months of July and August and September, and at such other times as a meeting may be called by the Chairman of the Council or upon petition of three members of the Council. It shall have its annual meeting for the purpose of organization and election of a Chairman at its first meeting following the annual meeting of the House of Delegates. Eight members of the Council which shall include four Councilors elected by county associations and four others, shall constitute a quorum for the transaction of business.

Par. 2. Each of the Councilors elected from county associations shall be entitled to cast two votes when actions are desired by the Council, and each of the other members



the "well-trained" amine



Seven years of search and synthesis in the Upjohn laboratories culminated in the development of Orthoxine Hydrochloride—a bronchodilator and antispasmodic. Orthoxine's dependable action gives relief to the asthma patient with minimal vasopressor and psychomotor stimulation.

Orthoxine Hydrochloride is administered orally.

℞ Orthoxine* HYDROCHLORIDE

(BRAND OF METHOXYPHENAMINE)

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) Tablets contain beta-(ortho-methoxyphenyl)-isopropyl-methylamine hydrochloride—a bronchodilator and antispasmodic.

*Trademark, Reg. U. S. Pat. Off.

a product of **Upjohn Research** for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY KALAMAZOO MICHIGAN

of the Council shall be entitled to one vote, except the Literary Editor of the JOURNAL who shall not vote.

Section 3. Duties

Par. 1. The Council shall have the power to act for the House of Delegates between meetings of that body and shall report such actions to the House of Delegates at its next meeting.

Par. 2. The Chairman of the Council and the Councilor from each county shall be the Nominating Committee of the Society. The Chairman of the Council shall be the chairman of this committee. The committee, after consultation and advising with the entire Council, shall report its nominations to the first session of each annual meeting of the House of Delegates. Following this report nominations may be made from the floor.

Par. 3. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or a general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken, and its decision in all such matters shall be final.

Par. 4. The Council shall serve as a board of review for cases of claimed malpractice referred to it by the Committee on Medical Ethics and Deportment of any component county association.

Par. 5. The Council shall be the finance committee of the Society and shall superintend and direct all financial transtions of the Society and shall prepare and submit annually to the House of Delegates a budget for the operation of the Society.

Par. 6. The Council shall make an annual report to the House of Delegates.

ARTICLE X

COMMITTEES

Section 1. Standing Committees

Par. 1. The Standing Committees of the Society shall be as follows:

A Committee on Arrangements
A Committee on Postgraduate Education
An Editorial Board of the JOURNAL
A Committee on Honorary Members and Degrees
A Committee on Hospitals
A Committee on Industrial Health
A Committee on Medical Education and Licensure
A Program Committee
A Committee on Public Health
A Committee on State Legislation
A Committee on Public Relations
A Cancer Coordinating Committee
A Committee on Professional Relations
A Committee on Mental Health

Par. 2. Unless otherwise specified in these by-laws, nominations for these committees and their chairmen shall be made by the Nominating Committee and presented to the Annual Meeting of the House of Delegates.

Par. 3. All standing and special committees, except the Committee on Arrangements, shall make a written report to the Council before the first of April of each year for transmittal with recommendations to the annual meeting of the House of Delegates. The Council, in its discretion, may request that any standing or special committee make a semi-annual report in writing to the Council for transmittal to the semi-annual meeting of the House of Delegates.

Section 2. Special Committees

Par. 1. Special committees may be appointed by the Council or elected by the House of Delegates as may from time to time be required. Committees appointed by the Council shall make written reports to the Council as directed by it. Committees elected by the House of Delegates shall make written reports to the Council in the same manner as provided for standing committees.

Section 3. Duties of Committees

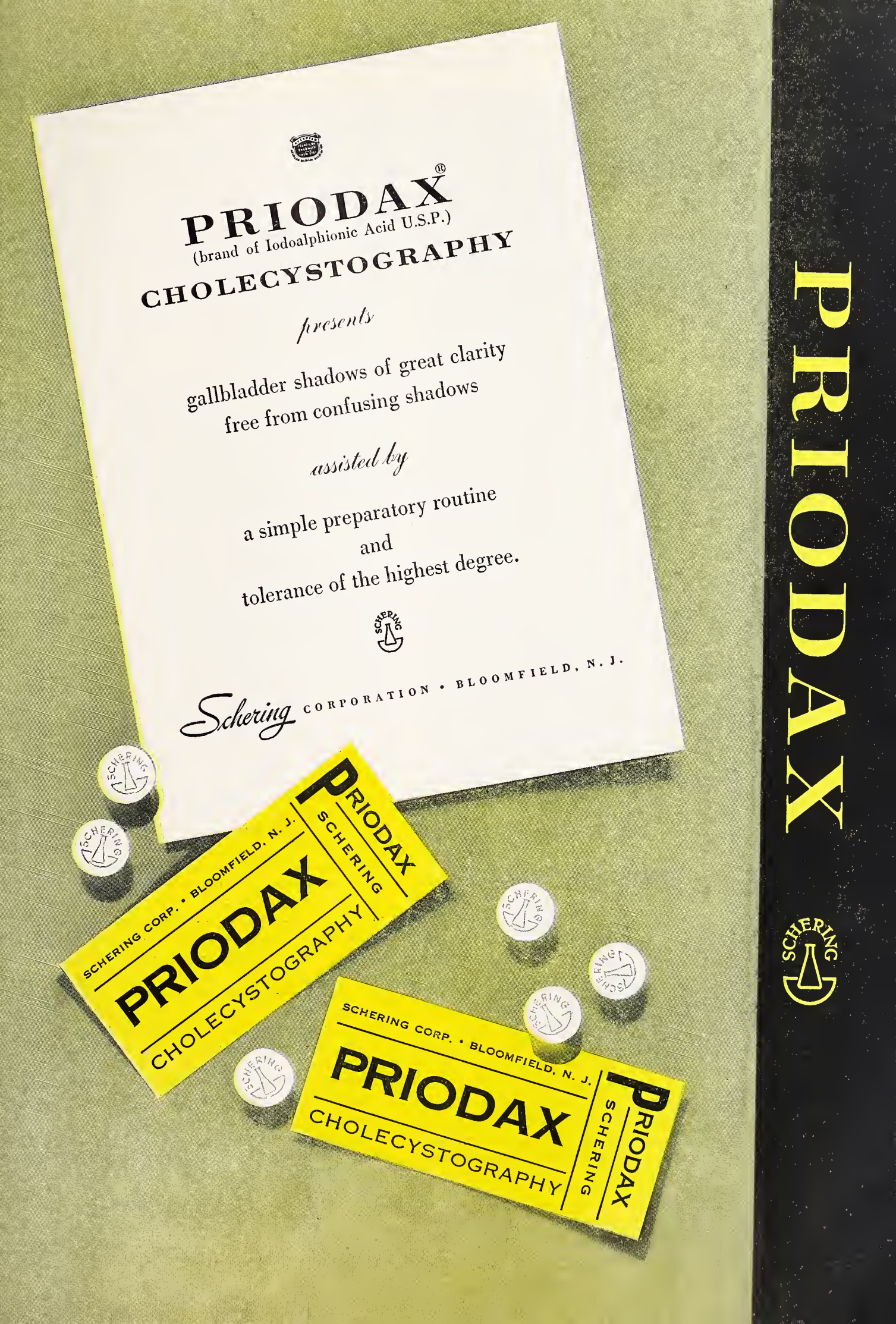
Par. 1. The Committee on Arrangements shall be appointed by the component association with which the annual session of the Society is to be held. It shall provide suitable accommodations for the meeting places of the Society, and of the special sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

Par. 2. The Nominating Committee shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society and to cooperate with university and other agencies within the state for the extension of postgraduate education of physicians.

Par. 3. The Nominating Committee shall nominate to the House of Delegates each year an Ediotrial Board of the JOURNAL, consisting of five members, and nominate the Chairman of the Board who shall serve as Editor-in-Chief of the JOURNAL. The Editor-in-Chief shall be a member of the Council. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest past presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Nominating Committee shall nominate an-


PRIODAX®
(brand of Iodoalphionic Acid U.S.P.)
CHOLECYSTOGRAPHY
presents
gallbladder shadows of great clarity
free from confusing shadows
assisted by
a simple preparatory routine
and
tolerance of the highest degree.
SCHERING
Schering CORPORATION • BLOOMFIELD, N. J.
SCHERING CORP. • BLOOMFIELD, N. J.
PRIODAX
CHOLECYSTOGRAPHY
PRIODAX
SCHERING
SCHERING CORP. • BLOOMFIELD, N. J.
PRIODAX
CHOLECYSTOGRAPHY
PRIODAX
SCHERING
PRIODAX
SCHERING

nually to the House of Delegates a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

Par. 7. At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the annual meeting of the Society, prepare such a program for submission to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Par. 9. The Nominating Committee shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society, in all matters pertaining to public health, sanitation, the prevention of communicable diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration desirable legal enactments to promote public health within the state.

Par. 10. Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation. In addition to these eight members, the Committee shall include the delegates to the American Medical Association and the Executive Secretary, who shall serve as the executive officer of the Committee. The chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this state, appropriate legislation for improving medical care and the public health within the state, advising the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

Par. 11. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members and nominate the chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and cooperate with other committees of the Society in a program of public relations.

Par. 12. The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee and nominate chairman thereof. The membership of this committee shall be not less than seven nor more than nine members and shall at all times includes the president of the Connecticut Cancer Society, the chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this committee shall be to cordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

Par. 13. At its semi-annual meeting in 1950 each component county medical association shall elect a past president of the association to serve on a state Committee on Professional Relations. The members so elected from the asocia-

tions in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951 at which time the Hartford, New London, Windham, and Middlesex County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield, and Tolland shall serve until the annual meetings of these county associations in 1952 at which time the New Haven, Fairfield, Litchfield, and Tolland County Associations shall elect a past president to serve on the state Committee on Professional Relations for a period of two years and such elections shall be held biennially thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except upon invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional malpractice or negligence. The purpose of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and, (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society's Secretary, either from the public or other physicians, they will be referred at once to the secretary of the county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with that county association. If in the judgment of the appropriate committee of the county association the complaint should be heard by the state Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association, to which a physician against whom charges have been brought belongs, shall not vote on the final conclusions reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arrival at a decision, shall notify the physician, against whom charges have been brought (by registered mail) of its findings and disciplinary action to be taken and at the same time, file a resume of its findings and action with the secretary of the county association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of this Committee shall have the right of appeal to the Council before the expiration of 15 days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

Par. 14. The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. This Committee shall be continually informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

ARTICLE XI

Funds and Expenses

Section 1. Funds

Par. 1. Funds for the operation of the Society shall be raised by an equal annual per capita assessment from each member of a component county association, except:

Par. 2. Members who are elected to the county associations at the semi-annual meetings will be assessed one-half of the annual dues for the year of their election.

Par. 3. Members who have been in good standing in the Society for 40 consecutive years or who have attained the age of 68 and have been members of the Society for 15 years immediately preceding shall be exempt from further payment of dues upon written request addressed to the Treasurer of the Society by the Secretary of the County Association in which the physician seeking exemption is a member and shall continue as active members of the Society enjoying all rights and privileges.

Par. 4. The dues of any member may be remitted by vote of the Council on recommendation of a County Councilor.

Par. 5. All funds of the Society shall be depostied promptly upon receipt in a state or national bank located in the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on January 1 and terminate on December 31 of each year.

Section 2. Budget

Par. 1. The annual budget of the Society shall be prepared by the Council, as the Finance Committee of the Society, and be presented to the House of Delegates for approval. Based upon that budget the Council shall recommend to the House of Delegates the amount of per capita assessment for the ensuing fiscal year. All requests and resolutions appropriating funds of the Society shall be referred to the Council for recommendation to the House of Delegates and all such requests and recommendations must be approved by the House of Delegates before funds may be expended.

Section 3. Fidelity Bonds

Par. 1. The Council shall prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society.

ARTICLE XII

Referendum

Section 1. Referendum

Par. 1. A general meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII

Component County Associations

Section 1. Component County Associations

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham Counties now in operation and in affiliation with The Connecticut State Medical Society shall be the component county association of this Society.

Section 2. Function

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1, of these By-Laws.

Section 3. Eligibility for Membership

Par. 1. All registered physicians licensed under Article 2747 of the General Statutes of the State of Connecticut, 1930, as amended, who have resided and practiced under that license in the State of Connecticut for one year shall be eligible to apply for membership except that student members transferring to active membership as provided in Article V, Section 3, Paragraph 4, shall not be required to reside in Connecticut one year before becoming eligible.

Section 4. Application for Membership

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

Section 5. Transfer of Membership

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credentials Committee of the component association in this state in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association without regard to the residence requirement prescribed in Section 3 of this Article.

Section 6. Membership Roster

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name, address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

Section 7. Discipline

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this decision shall be final.

Section 8. Termination of Membership

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

Section 9. Delegates to the House of Delegates of the Society

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any additional part of that number. Component associations with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number

of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the annual meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the State Society of the appointment at once and before the alternate delegate may be seated in the House of Delegates.

Section 10. Dues

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1 of each year and the component county associations shall forward all monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January of each year.

Section 11. By-Laws

Par. 1. The component county associations shall have the power to adopt only such by-laws as are not in conflict with the by-laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the by-laws of the Society shall take precedence over those of a component county associaiton.

ARTICLE XIV

Amendments

Section 1. Amendments

Par. 1. The by-laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the by-laws shall be submitted first to the Council and published, with the Council's recommendation, in the Connecticut State Medical Journal at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates in the notices of the meeting at which the amendments are to be acted upon.

ARTICLE XV

Parliamentary Procedure

Section 1. Rules of Order

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Robert's Rules of Order.

Section 2. Enablement Clause

Par. 1. The adoption of these by-laws rescinds and revokes all previous by-laws of the Society and supercedes their operation.

CROTON MANOR SANITARIUM
ALBANY POST ROAD, ROUTE 9
CROTON-ON-HUDSON, N. Y.
Tel. Croton 1-4731

A private sanitarium for individual care and treatment of nervous and mental disorders; senile and habit cases. Beautifully furnished. Overlooking Hudson River. Every room with bath. All accepted therapies administered. Brochure on request. Licensed by New York State Department of Mental Hygiene and approved by the American Medical Association.

Filomena Doherty, R.N., *Director*
George L. Lake, M.D., D.P.N., *Physician-in-Charge*
35 miles from New York City

ORTHOPAEDIC APPLIANCES
BUILT TO
PHYSICIANS' PRESCRIPTIONS
ONLY

SHIRLEY BROS.
26 ASHLEY STREET, HARTFORD
Phone 6-3748

Braces - Belts - Etc.
ESTABLISHED 1910

$1,000,000.00
has been salvaged from unpaid medical bills at no cost to our clients

Send this ad for details

Crane Discount Corporation
230 W. 41 St. New York 18, N. Y.
ESTABLISHED 1933

THE
REGAN CLINICAL LABORATORY
27 ELM STREET, NEW HAVEN, CONN.

Serving the physicians of New Haven since 1923

6 Technicians — 24 hour service

Technician automobiles equipped with radio phones to facilitate prompt dispatching

MILFORD LABORATORY
69 BROAD STREET, MILFORD, CONN.
Tel. 2-1153

To serve the Physicians for the analysis of blood, urine, etc.
E.K.G. and Basal Metabolism readings

GEORGE S. ZUCCALA, *Medical Technologist*
F.A.C. M.T. *Director*
24 hours service

Keep medicine in the hands of M.D.s.

Pepperidge Farm
WHOLE WHEAT
Bread



Made from undegerminated flour containing all the natural vitamin elements of wheat, including the wheat germ in its natural form. The flour is stone-ground fresh daily in an old New England grist mill. Each loaf is hand-kneaded, and only 93-score creamery butter, fresh whole milk, unsulphured molasses, honey, cane-syrup, salt, water, and yeast are used.

Our White Bread is made with unbleached white flour.

For information about our special SALT-FREE Bread, please write to:

MARGARET RUDKIN, Director
PEPPERIDGE FARM NORWALK, CONNECTICUT

PATRONIZE

YOUR

ADVERTISERS

Table of Contents : March 1952

Surgical Methods in Treatment of Carcinoma of Cervix
Langdon Parsons, M.D., Boston, Mass. 155

The Hernia Problem in Children — Robert A. Bonner, Jr., M.D., Waterbury 160

Detection of Clinically Unsuspected Carcinoma of Cervix in Office Practice by Vaginal Smear
Ralph C. Wright, M.D., and Donald A. Bristoll, M.D., New Britain 162

The Present Status of Diagnosis and Treatment of Thyrocardiac Disease
Charles K. Friedberg, M.D., New York City 164

Are Veterans People? — Richard Warren, M.D., Boston, Mass. 171

EDITORIALS

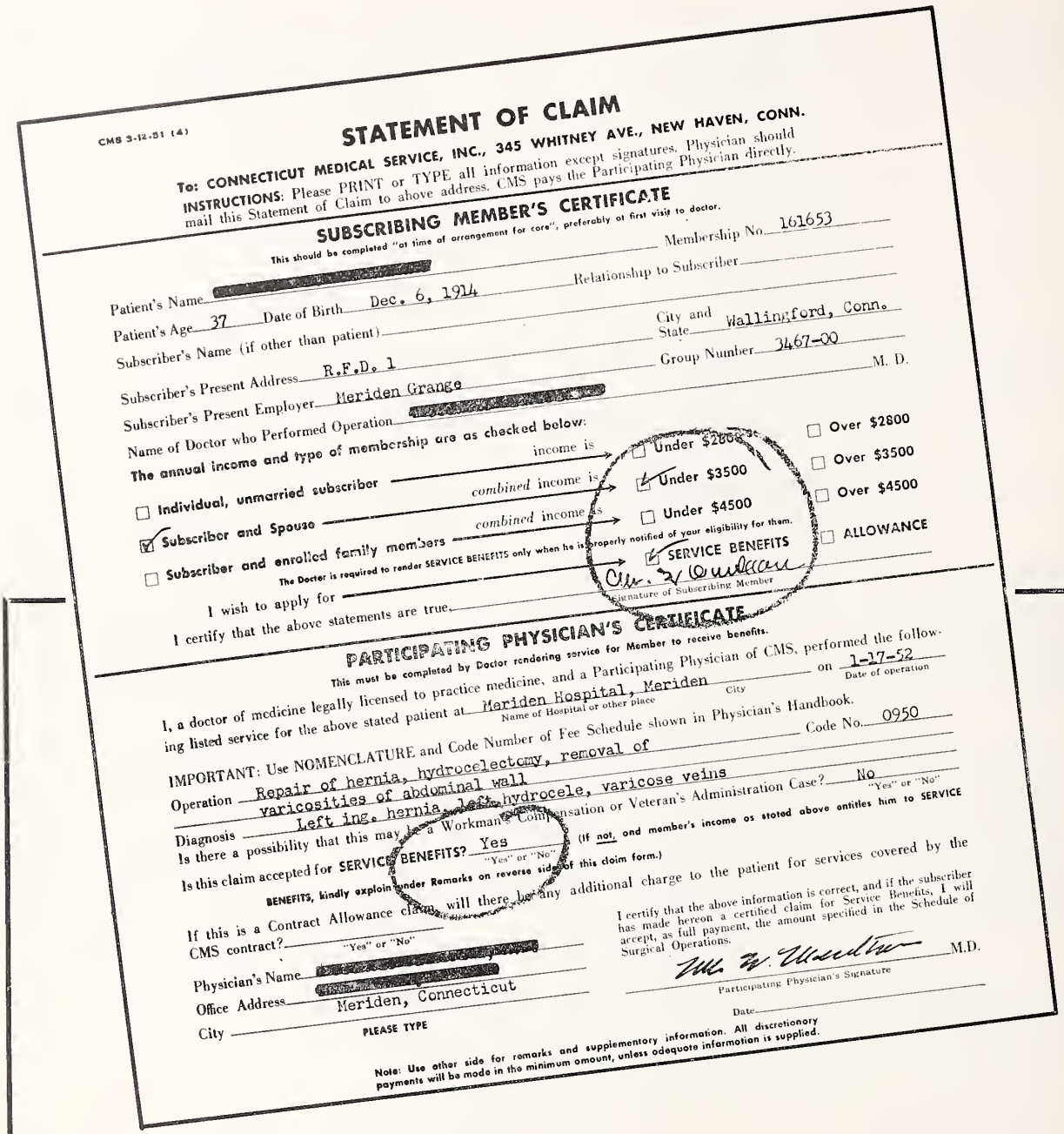
Medical Education and Medical Practice 178
The Health-Needs Commission 179
The Journal of the Student American Medical Association 179
Are Veterans People? 180
The Red Cross 180
Alcoholic Patients in General Hospitals 181
The County Medical Society 181
Committee on Foods, Drugs, Cosmetics and Devices 181
Francis Gilman Blake 182
Psychosomatic Medicine 182

DEPARTMENTS

Progress in Clinical Medicine
Tuberculous Pleurisy With Effusion: Its Significance and Management
C. P. LeRoyer, M.D., Beverly, Mass. 184
The President's Page 187
The Secretary's Office 190
Public Relations 194
News From Washington 196
Military Affairs 202
From Our Exchanges 204
Woman's Auxiliary 209
Our Neighbors 216
News From County Associations 216
News From Yale University School of Medicine 220
New Books in Review 220

MISCELLANEOUS

Program—160th Annual Meeting State Medical Society 174
The Fulltime Employment of Physicians in Connecticut
Creighton Barker, M.D., New Haven 182
Program—Connecticut Cancer Conference 188
Programs—Annual County Association Meetings 189
The Doctor's Office 192
Bone Saw and Drill Table
Charles Weer Goffe, M.D., Hartford 193
Obituaries
Harold Sears Arnold, M.D. 206
Robert J. Cook, M.D. 207
Special Notices 212



CMS 3-12-51 (4)

STATEMENT OF CLAIM

To: CONNECTICUT MEDICAL SERVICE, INC., 345 WHITNEY AVE., NEW HAVEN, CONN.

INSTRUCTIONS: Please PRINT or TYPE all information except signatures. Physician should mail this Statement of Claim to above address. CMS pays the Participating Physician directly.

SUBSCRIBING MEMBER'S CERTIFICATE

This should be completed "at time of arrangement for care", preferably at first visit to doctor.

Patient's Name [redacted] Membership No. 161653

Patient's Age 37 Date of Birth Dec. 6, 1914 Relationship to Subscriber

Subscriber's Name (if other than patient)

Subscriber's Present Address R.F.D. 1 City and State Wallingford, Conn.

Subscriber's Present Employer Meriden Grange Group Number 3467-00

Name of Doctor who Performed Operation [redacted] M. D.

The annual income and type of membership are as checked below:

☐ Individual, unmarried subscriber — income is → ☐ Under $2600 ☐ Over $2800

☑ Subscriber and Spouse — combined income is → ☑ Under $3500 ☐ Over $3500

☐ Subscriber and enrolled family members — combined income is → ☐ Under $4500 ☐ Over $4500

The Doctor is required to render SERVICE BENEFITS only when he is properly notified of your eligibility for them.

I wish to apply for → ☑ SERVICE BENEFITS ☐ ALLOWANCE

I certify that the above statements are true. Signature of Subscribing Member

PARTICIPATING PHYSICIAN'S CERTIFICATE

This must be completed by Doctor rendering service for Member to receive benefits.

I, a doctor of medicine legally licensed to practice medicine, and a Participating Physician of CMS, performed the following listed service for the above stated patient at Meriden Hospital, Meriden (Name of Hospital or other place, City) on 1-17-52 (Date of operation)

IMPORTANT: Use NOMENCLATURE and Code Number of Fee Schedule shown in Physician's Handbook.

Operation Repair of hernia, hydrocelectomy, removal of varicosities of abdominal wall Code No. 0950

Diagnosis Left ing. hernia, left hydrocele, varicose veins

Is there a possibility that this may be a Workman's Compensation or Veteran's Administration Case? No ("Yes" or "No")

Is this claim accepted for SERVICE BENEFITS? Yes ("Yes" or "No") (If not, and member's income as stated above entitles him to SERVICE BENEFITS, kindly explain under Remarks on reverse side of this claim form.)

If this is a Contract Allowance claim, will there be any additional charge to the patient for services covered by the CMS contract? ("Yes" or "No")

I certify that the above information is correct, and if the subscriber has made hereon a certified claim for Service Benefits, I will accept, as full payment, the amount specified in the Schedule of Surgical Operations.

Physician's Name [redacted]

Office Address [redacted]

City Meriden, Connecticut PLEASE TYPE

Participating Physician's Signature M.D.

Date

Note: Use other side for remarks and supplementary information. All discretionary payments will be made in the minimum amount, unless adequate information is supplied.

SERVICE BENEFITS *Convince* YOUR PATIENT of the merits of VOLUNTARY MEDICAL PRACTICE

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. XVI MARCH, 1952 No. 3

SURGICAL METHODS IN THE TREATMENT OF CARCINOMA OF THE CERVIX

Langdon Parsons, m.d., *Boston, Massachusetts*

The Author. *Professor of Gynecology, Boston University School of Medicine; Chief of Gynecology, Massachusetts Memorial Hospitals*

The proper treatment of carcinoma of the cervix offers the medical profession a challenge. Although metastases to lung or bone occur, the disease, unlike carcinoma elsewhere, tends to remain localized to the cervix throughout the greater part of its course even to terminal issue, death for the most part resulting from uremia and sepsis.

At the present time two out of every five patients treated by accepted therapy survive after five years. This represents a poor salvage rate for a form of malignancy that can be both seen and felt.

The treatment of cervical cancer today depends on radiation and surgery either alone or in combination. There is no indication that the future will bring much in the way of change. By employing surgery and radiation, where they will be most effective, it is now possible to individualize treatment of these patients.

But there seems at the moment to be considerable doubt as to where and when radiation or surgery should be used.

In the armamentarium of treatment surgery has a definite but only a selective place.

Extension of cancer beyond the cervix presents the average surgeon with rather more of a problem than he can hope to deal with adequately. It is because this fact is little understood that too many operations are now being performed on patients who might better have been given radiation.

Since at the first examination 75 per cent of women with cervical malignancy show evidence of disease beyond the confines of the cervix, radiation remains the basic form of therapy.

The selective nature of surgical treatment in cancer of the cervix can perhaps be best emphasized by considering the life history of the disease as expressed by the International Classification which reports the results of treatment in relation to the extent of the primary disease.

Stage I. The only essential requirement here is that the disease be confined to the cervix. The growth may be large or small or arise from one or both lips of the cervix. Its size has a definite bearing on prognosis. Another factor to be considered is the type of growth. The cauliflower or exfoliating growth, for example, bleeds easily on trauma. The symptoms therefore appear early and invasion occurs late. The ulcerative type on the other hand invades early and is not infrequently hidden within the endocervix thus escaping early detection.

Also since one can evaluate the extent of the process only by inspection and palpation it is possible to underestimate it. Approximately 17 per cent of carcinomas believed to be confined to the cervix will have undetectable regional metastases in the iliac and obturator area.

If radiation is used 65-70 per cent of the patients may be expected to survive 5 or more years. The fact that the figure is not higher may have something to do with undetectable metastases.

The optimum place for surgery is obviously in cases within this classification. Meigs'[1] report of the results of the Wertheim hysterectomy combined with bilateral pelvic lymphadenectomy shows a 5 year salvage of 80.7 per cent. In this series the cases were selected under very rigid specifications. The patients chosen were not only young, thin and in good general condition but more important the cancer had to be confined to the cervix or the immediately adjacent vaginal wall.

Presented at the Connecticut Clinical Congress, New Haven, September 12, 1951

Inasmuch as cancer of the cervix may occur in the obese or over-age patient not all cases of cancer of the cervix have been offered operation. The survival figures for patients treated by radiation on the other hand include all patients with Stage I growths who presented themselves for treatment.

Unfortunately only 20 per cent of patients seen fall within the Stage I classification. The results from radiation or surgery in these are excellent, a fact which underlines the cardinal importance of early diagnosis. The prognosis for cervical carcinoma is directly referable to the size of the primary lesion whether the treatment be radiation or surgery. With an alert medical profession and cancer conscious public we should improve on the figure of 20 per cent.

Stage II. Approximately 45 per cent of all cases seen belong in this category. A Stage II lesion has spread beyond the confines of the cervix to involve the paravaginal and paracervical tissues without actually involving the side wall of the pelvis.

This classification gives us wide latitude in evaluating the extent of the disease. The lesion may, for example, have begun to extend to the vaginal wall, on the one hand, or the patient may be dying from obstruction of both ureters due to paracervical extension. Both cases are in Stage II but are hardly comparable on the basis of therapy evaluation. Since the morbidity, mortality and recurrence risk are much higher where the disease is more extensive, it is important to know, when considering radical surgery for a growth in Stage II, whether one is dealing with early infiltration of the vaginal wall or with disease extensive enough to occlude the ureter. Surgery may be offered to the former but should not be attempted in the latter. According to Schmitz,[2] for every mm. of extension beyond the original site of the growth, the survival rate drops. The reported results of therapy will naturally vary widely depending on the nature of a Stage II neoplasm. From the Radiumhemmet in Stockholm, Kottmeier[3] reports a 5 year survival of 52 per cent of 1,029 Stage II cases treated by radiation. Schmitz,[2] using higher voltage therapy, reports a 70 per cent salvage. The difference in salvage rate is in part due to the type of case within Stage II that is presented for treatment.

In the Stage II classification the selection of cases for surgery is even more stringently made than in the Stage I category. In this very carefully selected group Meigs reports[1] a 60.7 per cent survival for the extended surgical procedure.

For the Stage II growths the basic treatment should be radiation.

Stage III. In this stage, the side wall of the pelvis has become involved either by direct extension or metastases to the regional nodes from what may be a relatively small primary neoplasm. The ulceration is usually extensive. Unless the surgeon is prepared to perform surgery of the magnitude of Brunschwig's pelvic exenteration, there is no place for surgery in this classification.

With radiation a 25 per cent survival figure is possible.

Stage IV. Here the adjacent organs have become involved. Surgery, except for the pelvic exenteration procedure, cannot be considered.

With radiation, the 5 year salvage figure varies from 0 to 10 per cent.

As we review the problem in terms of the relationship between treatment and extent of the disease we see that radiation remains the basic form of treatment with surgery limited to certain selected cases.

Why then do we consider surgery at all? Surgery as a method of treatment has returned to stay for very definite reasons. In the first place certain patients are radiation resistant. It is difficult to recognize these cases early in the course of treatment. Except for the interpretation of vaginal smears as suggested by Ruth Graham[4] and the evaluation of the biopsy taken during the course of treatment by Glucksman[5] in England we have no way of determining this resistance. It would appear safer to accept the risks of surgery provided the approach was radical enough to be effective.

Another cogent reason for the return of surgery is the reasonable doubt in the minds of radiologists, pathologists and surgeons alike of the value of external radiation in eradicating malignancy in the regional nodes. The results of radiation therapy in breast cancer and regional extension to the neck of primary cancer of the lip and tongue have not been encouraging. In these areas the regional nodes are relatively superficial and confined. The problem is accentuated in cervical carcinoma, where the area of potential spread extends to the side walls of the pelvis from the umbilicus to the symphysis, so that the positive node may possibly lie outside the field of radiation. In such accessible areas as axilla, neck and groin, clinical evaluation of extension of disease

carries a 30 per cent error. The error will be much higher in the pelvis. The radiologist is therefore committed to deliver a uniform cancericidal dose to the entire pelvis and at varying depths from the skin. It is not surprising then that nodes within the field of radiation are not destroyed. It would seem logical to increase the dosage but here limiting factors present themselves, such as the danger of damage to adjacent viscera—bladder, rectum and small bowel. In this respect supervoltage x-ray therapy has been a decided improvement, but therapists skilled in its use are nevertheless skeptical of their ability to destroy cancer in regional nodes.

How often then do these nodes become involved? They have been found in 17 per cent of Stage I, 28 per cent of Stage II and 40 per cent of Stage III cases. If serial sections were performed on all the nodes removed, the percentage might even be higher. In breast cancer, a 30 per cent increase in positive nodes was discovered by this method. If the regional nodes appear as often as they seem to do and there is reasonable doubt of the curative power of external radiation, then we have another valid reason for preferring surgical treatment.

We must keep in mind that experimentation is still going on in the field of radiation.

Surgery was never meant entirely to supplant radiation. Like radiation, surgery also has its limitations. The treatment of cancer of the cervix must be suited to the individual case. For some, radiation is best; for others, surgery. No one form of treatment should be advocated to the exclusion of the other. Modern surgical techniques, supplemented by newer concepts of postoperative management, blood and fluid replacement and chemotherapy, make surgery safe in cases of cervical cancer. The patient must be properly selected, however, and the surgery adequate, if the results are to approach those achieved with radiation.

As already emphasized, the criteria for surgery are highly specific ones. In the confusion as to where surgery belongs in the treatment of cervical cancer, these criteria have not been clearly defined or are being willfully ignored.

A good candidate for the radical Wertheim procedure combined with bilateral pelvic lymphadenectomy as advocated by Meigs[6] must be relatively young, thin and in good general condition. It is even more important that the neoplasm be entirely confined to the cervix or the immediately adjacent vaginal wall; in other words, only certain selected cases in the Stage I and II classifications are operable. To extend the operable limits to include the more obese patient or the one with more extensive disease is to risk increasing the morbidity, mortality and recurrence rate and markedly lowering the salvage rate.

Not only is there considerable misunderstanding as to what patients should be offered surgery but there is considerably more as to what constitutes adequate surgery. We still see carcinoma of the cervical stump after supravaginal hysterectomy. But now we are encountering a startling number of patients with cancer of the cervix on whom merely a simple total hysterectomy was performed. In some of these cases, the cancer is an accidental finding. Both these situations could have been prevented by the simple expedient of performing a preliminary diagnostic curettage whenever pelvic laparotomy was indicated. Many of the total hysterectomies are called Wertheim operations when actually they represent nothing more than an extension of the total hysterectomy commonly performed for a benign fibroid or for cancer of the endometrium. It is comparable to a simple amputation in a case of breast cancer. The life histories of endometrial and cervical cancer are totally different. A surgical procedure considered adequate for the first is hopelessly inadequate for the latter. Within the past year 25 per cent of the women with cancer of the cervix admitted to the Massachusetts State Cancer Hospital at Pondville—most of them in their mid-thirties—had had a previous total hysterectomy. The rapidity and extent of recurrence was such that pelvic exenteration alone could be performed, making for a situation little short of tragic.

If we are to do surgery it must be adequate. Healey[7] observes that "inadequate or excessive radiation is as bad for the patient as incompetent or bungled surgery." One might go further and say that poor surgery is far worse than poor radiation. At the present time the wrong operation is being performed on the wrong patient. What then constitutes a correct and adequate surgical procedure? The Wertheim operation as revived by Meigs[8] calls for a bilateral pelvic lympadenectomy, together with removal of the entire uterus and adnexae, including the entire block of paracervical and paravaginal tissue in and around the bladder base. It is not enough to take out the uterus along with a wide cuff of vaginal epithelium and dissect the nodes. Most important by far is the lympatic-bearing area around

the bladder neck. If cancer of the cervix extends, it will invariably involve this area. Palpation not infrequently fails to discover its existence. To remove this block of tissue satisfactorily, one must dissect the ureters throughout their course into the bladder neck and mobilize the base of the bladder. It cannot be resected otherwise. Not to remove it means almost certain recurrence. This procedure is a far cry from total hysterectomy. Mobilizing the ureter and bladder increases the risk of damaging them. In the early experience with the Wertheim operation uretero-vaginal fistulae were not uncommon. Today, as the paravaginal and paracervical dissections have become more radical, the morbidity revolves around re-establishing bladder tone lost by the interruption of nerve supply.

Unless the surgeon is prepared to be radical in his approach the patient had best have radiation. There is nothing about surgery for cancer of the cervix that a properly trained surgeon cannot learn, provided he is willing to do so, but even a good surgeon who has learned the technique should not attempt it if he sees only an occasional case a year.

The results achieved with the Wertheim type hysterectomy plus the pelvic lymphadenectomy are not available from any large group of cases. Enough time has elapsed to indicate an 80.7 per cent survival for Stage I and a 60.7 per cent for Stage II growths. These figures, reported by Meigs, compare favorably with the best results that have been reported with radiation. But one must bear in mind that only the most favorable cases in the Stage I classification were selected for surgery. No such selection of patients was made in the radiation series, which included all candidates who presented themselves for treatment. One other factor must be kept in mind. As yet there are no mass statistics to prove that surgery is superior to radiation for curing involved nodes. Bonney[8] reports cure in 20 per cent of cases with nodal involvement. Meigs[10] gives a 5 year survival figure of 35 per cent. Had the 35 per cent succumbed if radiation had been used instead of surgery, this figure could be taken as salvage. Actually we are not yet in a position to know.

EXTRAPERITONEAL NODE DISSECTION

For the 70 per cent of patients in whom cervical cancer is too extensive for even radical surgery to be effective, a combination of radiation and surgery may be used.

Assuming x-ray treatment to be ineffective for metastases of cervical cancer to nodes, Taussig[11] originally advocated an intra-abdominal pelvic lymphadenectomy either preceding or following a combination of radium and x-ray. But the technical difficulties encountered in the obese patient sharply limit the practicability of this very logical maneuver. Nathanson[12] then suggested extraperitoneal node dissection, which gives better exposure and can be more readily applied to the overweight patient. The procedure, whether performed intra-abdominally or extraperitoneally, simply adds to the standard radiation therapy a surgical attack on the regional nodes. The accepted method of treating cervical cancer is in nowise changed. No attempt is made to solve the problems of local recurrence, radiation resistance or extension of the disease beyond the cervix; with these stumbling blocks the radiologist must still deal.

The Nathanson procedure is performed 3 months after the patient has had a complete course of radium combined with x-ray therapy, provided that clinical evaluation supplemented by vaginal smear and biopsy has uncovered no suggestion of local disease. The operation is useless unless the local disease has been cured.

Enough time has not elapsed to evaluate the procedure in terms of longevity. In a series of 50 cases[13] in which a full course of x-ray treatment was followed by radium, involved nodes were found in 28 per cent. All but 3 patients had a Stage II growth. This is about the normal incidence of positive nodes without radiation. The cases were about equally divided in receiving 200-400 and 1200 KV therapy. The value of x-ray therapy in curing involved nodes is again open to question. Unfortunately we cannot evaluate surgical treatment in this respect since in all the cases presenting evidence of node involvement the local disease had not, despite clinical impression to the contrary, been cured.

The procedure, though experimental, seems logical, but will most certainly fail if the local disease is not eradicated.

ULTRARADICAL SURGERY

There remains to discuss Brunschwig's[14] highly experimental pelvic exenteration. This procedure is used in the extreme cases which fail to respond satisfactorily to any amount of radiation therapy. Despite the fact that these patients have extensive fatal disease persisting in the pelvis, these patients appear in excellent condition. Any further attempt

to control the disease by irradiation is by and large unsuccessful. Longevity is not prolonged and the patient is frequently made more miserable.

For these extreme cases surgery would seem to be illogical were it not that in 40 per cent of the patients coming to autopsy the neoplasm is found to be confined to the pelvis. Remote or late metastases are relatively rare. The surgeon with the courage and the proper training to handle this type of problem ought to be able to salvage at least a few of these patients.

Brunschwig's extensive procedure calls for bilateral pelvic lymphadenectomy together with bloc-removal of the uterus, vagina, bladder, rectum and vulva. The bladder or rectum may sometimes be spared. Diversion of the urinary stream is accomplished either by ureterocolostomy or skin ureterostomy. No vital structures other than the excretory apparatus are involved. The technical difficulties are formidable, and the postoperative problems endless. The mortality rate is about 25 per cent, with no operating room deaths.

My own experience with 60[15] such cases confirms Brunschwig's findings in a much larger series, that patients can survive such surgery to live happy and useful lives. Were it not possible for them to live fairly normally I would seriously question the value of surgical interference. To this end I am also convinced that a careful selection of candidates for this operation is imperative.

The longevity figures offer some encouragement. Despite the technical problems involved in a new procedure and the extensiveness of the disease process in these cases, 13 of 35 patients (38 per cent) who underwent this operation more than 1 year ago survived. Of 28 patients operated over 2 years ago, 9 (33 per cent) survived without disease. The patient who has survived longest (3.5 years) teaches school and drives her own car.

Although this procedure is experimental, we must be prepared—if we are to consider surgery at all in advanced cases, radiation resistant patients or where radiation has failed—to perform this radical operation or not operate at all. To date the operation has for the most part been used for patients who have been refused further radiation, and, less often, in a few cases with massive involvement of bladder and rectum where no radiation has been given.

There is another context where this ultraradical surgery may be useful. If we elect surgery as the primary mode of treatment in surgical cancer we must be equipped to go to any lengths to cure the patient. We may, for example, find that we have been led by negative preoperative observation, cystoscopy, intravenous pyelogram or digital examination to underestimate the extent of the disease, which at operation we discover to have involved the bladder, encroached on the rectum or surrounded the ureter. Anything short of removing the bladder together with the uterus and nodes would obviously be hopelessly inadequate, and the surgeon should be prepared to go to the necessary lengths to handle such an emergency when it arises.

Surgery of this magnitude should not be undertaken unless one is thoroughly aware of the formidable technical and physiological problems which these patients present. Nor should it be attempted without highly specialized facilities and a staff trained to cope with the multitude of postoperative complications.

CONCLUSIONS

Surgery has a definite but limited place in the treatment of cancer of the cervix. Radiation remains the basic therapy. Candidates for surgery as primary treatment must be excellent risks and the disease limited to the cervix or immediately adjacent vaginal wall. The surgical procedure must be adequate. A total hysterectomy with or without node dissection cannot be regarded as sufficient. Retroperitoneal node dissection performed after complete radiation, may, although experimental, prove valuable in future treatment plans. For advanced or previously irradiated cases the pelvic exenteration procedure should be regarded as highly experimental. The longevity figures are encouraging.

BIBLIOGRAPHY

1. Meigs, J. V.: Am. J. Obst. & Gynec. 62:854, 1951.
2. Schmitz, H. E.: Am. J. Roent. 65:716, 1951.
3. Kottmeier, H. L.: Am. J. Roent. Discussion, Brunschwig, A. 65:723, 1951.
4. Graham, R. M.: Surg. Gynec. & Obst. 84:153, 1947.
5. Glucksman, A., and Spaer, F. G.: Brit. J. Rad. 18:313, 1945.
6. Meigs, J. V.: Am. J. Roent. 57-679, 1947.
7. Healey, W. P.: Am. J. Roent. Discussion, Brunschwig, A. 65:722, 1951.
8. Meigs, J. V.: Progress in Gynecology, New York, 1950, Grune & Stratton, p. 540.
9. Bonney, V.: Textbook of Gynecological Surgery, New York, 5th Ed. Paul Hoeber, 1948, p. 356.

10. Meigs, J. V.: Am. J. Roent. 65:707, 1951.
11. Taussig, F. J.: Am. J. Obst. & Gynec. 28:650, 1934.
12. Nathanson, I. T.: Progress in Gynecology, New York, 1950, Grune & Stratton, Vol. II.
13. Meigs, J. V., Parsons, L., and Nathanson, I. T.: Am. J. Obst. & Gynec. 57:1087, 1949.
14. Brunschwig, A.: Cancer, I:177, 1948.
15. Parsons, L., and Bell, J. W.: Cancer, 3:205, 1949.

THE HERNIA PROBLEM IN CHILDREN
(A review of 236 hernias treated in two Waterbury hospitals)

Robert A. Bonner, Jr., m.d., *Waterbury*

The Author. *Associate Attending Surgeon, St. Mary's Hospital, Waterbury*

It is fair to say that the large majority of physicians are well grounded in what constitutes an inguinal hernia and are uniformly agreed that cure is achieved only by a suitable operation of hernioplasty. The differential diagnosis and even the general principles of the surgical operation itself are well understood. The complications of hernia are respected and the risks of hernioplasty are properly viewed and evaluated in most instances.

Notwithstanding the above statement, the problem of hernia presents specific problems in infancy and young children. What course of management proves best in handling the healthy newborn child who has regained birth weight and is progressing nicely except for an uncomplicated right inguinal hernia? What is the chance of "cure" when a properly fitted truss is used in the management of the early cases? What are the inherent dangers in truss therapy? Is surgery feasible in these cases? Such questions comprise the problem of hernia in children. With such questions only partially answered, it is small wonder that some physicians conclude that the child is better off with no treatment at all.

The present communication is a review of 236 hernias in children from birth through twelve years of age treated at both Waterbury hospitals from 1939 through 1948.

GENERAL STATEMENT

The most common congenital malformation admitted to hospitals is inguinal hernia. The large majority are first noticed between birth and the third month of postnatal life, 60 per cent occur on the right side, 20 per cent are bilateral, and 20 per cent on the left side. Ninety per cent are in the male. Six per cent become incarcerated with 30 per cent of such cases occurring in subjects previously undiagnosed as hernia. Incarceration has its peak incidence in the first six months of life and is strikingly less common after two years of age, and rare after six years of age. True strangulation (gangrene) is fortunately rare (0.004 per cent to 0.38 per cent).

Most all cases of cryptorchidism have an associated inguinal hernia. In many such cases the presence of the sac is not apparent clinically. The vast majority of hydroceles of the cord (non-communicating) have an associated patent vaginal process (hernia) above the hydrocele (80 per cent).

All communicating hydroceles are of course "scrotal" hernias and represent five per cent of all cases of congenital inguinal hernia.

In the diagnosis of uncomplicated inguinal hernia in children, the emphasis is on the history of a recurrent reduceable mass in the region. Repeated palpation may fail to yield conclusive evidence. Invagination of the scrotum is not a reliable method of examination in this age group.

The diagnosis of an incarceration should be followed by the degree of intestinal obstruction and strangulation felt to accompany this complication. The differential diagnosis of complicated inguinal hernia may be perplexing and difficult. Tortion of the testicle in the canal, hyrocele of the cord or canal of Nuck, inguinal or femoral adenitis, torsion of the descended testis and new growth make up the conditions approximating the syndrome of complicated hernia.

ANALYSIS OF CASES

There were 211 admsisions for inguinal hernia in children from birth through twelve years of age in the two general hospitals in Waterbury during a ten year period ending January 1, 1949. Two hun-

dred and one individual children were involved for a total of 236 inguinal hernias. Two hundred and twenty-one radical cures for hernia were performed to effect a cure in 220 hernias in 188 individuals. (It is not the intent of this paper to study the cure rate obtained in the management of these cases. However, a two and one half year period was allowed the most recently operated cases in this series. Recurrent inguinal hernia admissions in children were checked at both hospitals over this two and one half year period. No recurrences were found. It is highly probable that most recurrences, if not all, would turn up as local hospital admissions. Bartlett estimated that 66 per cent of inguinal hernia recurrences occur within the first two years and 83 per cent within five years; estimates based on a careful follow-up of 494 cases.) Thirteen individuals did not submit to operation with a total of sixteen hernias not treated by surgery. There were no deaths for admsision with inguinal hernia.

No cures were obtained by methods other than surgery, although thirty-seven hernias (15 per cent) were given one year or longer truss therapy. All but one case subjected to truss therapy were subsequently subjected to surgery. In two cases of truss management, an incarcerated hernia developed (5.4 per cent); a similar number developed the complication or severe dermatitis at the site of pressure of the truss. In the hernia cases not complicated by cryptorchidism, testicular atrophy did not appear as a complication in either the truss or the operative group.

There were sixteen individuals observed with a total of nineteen undescended testicles. Ten of these patients were operated upon and hernia was found in every instance. In one case, the diagnosis was not made at the time of the surgical correction for the undescended testicle and consequently the sac was not ligated. A second operation became necessary to correct the hernia. We have listed this case as the only recurrence of hernia in children submitted to operation in Waterbury over the ten year period covered. One other case of recurrence was noted in a child operated upon elsewhere. The record of this operation was not available. It would be interesting to ascertain whether or not the sac had been found and properly handled.

There were twenty-two cases of incarcerated hernia, an incidence of 9.3 per cent (high). Seventeen of these children were two years of age or under and none appeared in children of six years or older. One case occurred in a female. Fifty per cent of the incarcerated cases gave no previous history of inguinal hernia.

Two instances of true strangulation were recorded; neither case was resected. One case was a Richter's hernia and simple excision of the gangrenous area with closure of the bowel effected a cure. The second case was managed conservatively after it was apparent that the glistening serosa coat had not suffered and the bowel was viable. The strangulation rate in this series is 0.85 per cent, which is high.

One hundred and ninety-eight anesthetics were administered to the 188 patients. All cases were carried with drop ether except two, which were carried on gas-oxygen-ether by the closed machine. Almost all were induced by venethene. Nitrous oxide was employed for induction in several instances. One child was carried on avertin anesthesia. No children were operated upon by the use of the sugar tit and almost all had an adequate dose of atropine or scopolamine. Most children had some form of preoperative sedative.

The postoperative courses in 198 individuals were complicated by three instances of atelectasis (1.5 per cent). This entity proved to be the most severe complication. None of the three cases were subjected to bronchoscopic suction. Two out of three cases followed the one stage bilateral procedure. There were five instances of acute upper respiratory disease, three of pneumonitis, in three, postoperative vomiting requiring replacement of fluids parentally, three incisional hematomas required drainage. There were two instances of superficial oozing from the wound, seven minor wound infections, one adhesive dermatitis, and seventeen transient scrotal swellings. The one instance of recurrence was noted previously.

Prophylactic chemo or antibiotic therapy was carried out in 10 per cent, and parenteral fluids given in 13 per cent.

Thirty-one per cent of the hernias were noted from birth through three months of age, and 62 per cent before four years of age. Four per cent of the operated group were subjected to surgery from birth through three months of age, and 41 per cent were operated on before four years of age. Sixty-three per cent were operated on before six years of age.

No specialized postoperative dressing protectors were used and patients were not restricted in movement postoperatively. Seventy-four per cent of the cases were operated upon over the last five years of

the ten year period, and the longest postoperative stay was seventeen days, the shortest, two days. The vast majority were discharged between the fifth and the tenth day postoperatively.

CONCLUSION

(1) Infants and young children withstand the operation of radical cure for hernia better than adults.

(2) Surgery should not be withheld from this group of patients on the basis of such false reasoning as:

(a) Smallness of inguinal structures.

(b) Poor surgical risk because of age.

(c) High spontaneous cure or truss cure rates.

(d) High incidence of wound infection due to "wetting."

(e) Necessity of unnatural postoperative restraints.

(3) Results from surgery are uniformly excellent in contradistinction to management by truss methods, which yield uniformly poor results with many untoward complications. The potential dangers of hernia are not diminished with truss therapy and, with its use, emotional disturbances in both parents and child are of frequent occurrence.

BIBLIOGRAPHY

Bartlett, Jr., W.: "Concept of Inguinal Hernia Repair"—Surgery. Gynecology and Obstetrics. July 1946.

DETECTION OF CLINICALLY UNSUSPECTED CARCINOMA OF THE CERVIX IN OFFICE PRACTICE BY THE VAGINAL SMEAR

Ralph C. Wright, M.D., and Donald A. Bristoll, M.D., F.A.C.S., *New Britain*

The importance of the Papanicolaou smear as an effective instrument in the early diagnosis of carcinoma of the cervix is now well established. Most authors have stressed its usefulness as a screening procedure in carcinoma detection clinics, but there has been little emphasis on its place in the office practice of both the specialist and general practitioner. The purpose of this paper is to present the experience of the authors in the office use of the Papanicolaou smear for the diagnosis of unsuspected carcinoma of the cervix.

MATERIAL AND METHOD

During the period of March 1, 1950 through June 28, 1951, 383 Papanicolaou smears were taken in the office of the authors who limit their practice to obstetrics and gynecology. For the most part, smears were done only on those patients with minor cervical pathology such as erosions, polyps, chronic cervicitis, and those patients with a history of abnormal vaginal bleeding.

The technique used was a circumferential smear about the external cervical os with an Ayre spatulum. Three slides were prepared from each patient and fixed immediately in alcohol and ether. Following this, the slides were stained according to the Papanicolaou technique at the New Britain General Hospital, and interpreted by Dr. Paul Rosahn, pathologist in charge.

RESULTS

There were 383 patients included in this study and a diagnosis of carcinoma was made by Papanicolaou smear on 6.

CASE HISTORIES

Case No. 1. S. P. was a 36 year old gravida I para I who came to the office on May 31, 1951 for a routine pelvic examination. There was no metrorrhagia or leukorrhea. Speculum examination revealed a small cervical erosion. A Papanicolaou smear was positive and the cervical biopsy revealed intra epithelial carcinoma (carcinoma in situ).

Case No. 2. E. L. was a 37 year old gravida III para III who came to the office on August 28, 1950 because of intermenstrual spotting off and on during the past month. Speculum examination revealed a clean, normal cervix. A Papanicolaou smear was positive and microscopic examination of the cervical tissue revealed an early invasive carcinoma located just inside the external os.

Case No. 3. G. B. was a 25 year old gravida II para II who came to the office on January 12, 1951, because of vaginal

From the Grove Hill Clinic, New Britain, Connecticut, and the Department of Gynecology and Obstetrics of the New Britain General Hospital

discharge, and post coital spotting on two occasions during the past month. Speculum examination showed hypertrophy of the cervix, endocervicitis, and a rather extensive erosion. The Papanicolaou smear was positive and a knife cone biopsy of the cervix revealed intra epithelial carcinoma (carcinoma in situ).

Case No. 4. M. J. was a 43 year old gravida I para I who was seen in the office on January 3, 1951 for a routine pelvic examination. There was no vaginal discharge or history of metrorrhagia. Speculum examination revealed an infected cervix. The Papanicolaou smear was positive and subsequent biopsy revealed an early invasive carcinoma of the cervix.

Case No. 5. J. G. was a 39 year old gravida I para I who came to the office on May 8, 1951 because of vaginal discharge. There was no history of metrorrhagia. Speculum examination showed hypertrophy of the cervix, moderate endocervicitis, and a small erosion about the external os. A Papanicolaou smear was positive and a knife cone biopsy revealed intra epithelial carcinoma (carcinoma in situ) of the cervix.

Case No. 6. I. S. was a 36 year old gravida O Para O who came to the office on March 20, 1950. There were no pelvic complaints, but speculum examination revealed a large cervical erosion involving both anterior and posterior lips. The Papanicolaou smear was positive. Biopsy and conization were performed but microscopic examination of the tissue failed to reveal any evidence of malignancy. Numerous Papanicolaou smears at monthly intervals since the conization have all been negative. This case is therefore classified as a false positive, although the patient is to be followed carefully with repeated smears.

It will be noted that the diagnosis of carcinoma by Papanicolaou smear was confirmed by biopsy in 5 out of 6 instances. Two cases proved to be early invasive carcinoma of the cervix, while three were intra epithelial carcinoma (carcinoma in situ). There was one false positive report. This gives an incidence of one biopsy proven diagnosis of carcinoma in approximately every 76 cervical smears taken.

COMMENT

With present methods of therapy for carcinoma of the cervix, early diagnosis still remains the most important weapon in the reduction of mortality from this disease. Early carcinoma of the cervix frequently cannot be recognized on visual examination of the cervix for often the lesion is located just inside the external os and thereby overlooked on routine speculum examination. Frequently the lesion can not be differentiated from a cervical erosion and other forms of chronic cervicitis. Occasionally, there is no visible lesion even though an early intra epithelial (carcinoma in situ) malignancy is present.

The detection of 5 patients with carcinoma of the cervix during a 16 month period emphasizes the usefulness of the Papanicolaou smear in office practice. It will be noted that all five patients were under 44 years of age and none showed any gross lesion which was diagnostic of carcinoma on speculum examination. Such results make one speculate on the number of early cervical malignancies being overlooked in the office practice of both the specialist and the general practitioner who have not yet adopted the vaginal smear technique.

At present the expense to the patient and the physical limitation of laboratory facilities often curtail the use of the Papanicolaou smear. However, when expansion of laboratory facilities permit, it is hoped that the Papanicolaou smear may become an integral part of every gynecological examination carried out in office practice.

SUMMARY AND CONCLUSIONS

1. Three hundred and eighty-three patients were examined by Papanicolaou smears in the office during a 16 month period.

2. By means of these Papanicolaou smears, 5 patients with "unsuspected" early carcinoma of the cervix were discovered.

3. All 5 cases were confirmed by biopsy. Three were carcinoma in situ, and two were early invasive carcinoma of the cervix.

4. These results emphasize the value of the Papanicolaou smear in the detection of early carcinoma of the cervix not suspected on pelvic examination in the office.

5. More extensive use of the Papanicolaou smear in the office practice of the general practitioner as well as the specialist is urged.

THE PRESENT STATUS OF THE DIAGNOSIS AND TREATMENT OF THYROCARDIAC DISEASE

CHARLES K. FRIEDBERG, M.D., *New York City*

The Author. *Associate Attending Physician, The Mount Sinai Hospital, New York; Lecturer in Medicine, Columbia University*

THYROCARDIAC disease denotes a combination of hyperthyroidism with auricular fibrillation and/or congestive heart failure. But problems in the diagnosis of thyrocardiac disease differ in certain respects from those associated with uncomplicated hyperthyroidism. There are problems in the management of auricular fibrillation or of congestive heart failure in thyrocardiac disease which are not identical with those ordinarily encountered in the common forms of cardiac disease. The solution of these problems has been greatly facilitated by recent advances in diagnosis and treatment due to the more frequent determination of the serum precipitable iodine, the use of the thiouracil antithyroid drugs, and especially the availability of radioactive iodine (I^{131}).

DIAGNOSIS OF THYROCARDIAC DISEASE

DIAGNOSIS BY CLINICAL MEANS

The diagnosis of thyrocardiac disease involves the recognition of hyperthyroidism in addition to the more apparent auricular fibrillation and congestive heart failure. In a fair percentage of cases such classic findings as thyroid enlargement, ocular stare, tachycardia, rapid pulse, and warm moist skin are sufficiently clearcut to enable one to make the diagnosis both of hyperthyroidism and of cardiac disease. On the other hand, in a large number of patients with thyrocardiac disease the classic signs of hyperthyroidism are missing or obscured by the more overt evidence of heart failure and auricular fibrillation. These are the cases of so-called masked hyperthyroidism, which are particularly common in combination with cardiac disease. Exophthalmos is usually absent. Tachycardia, although present, is not helpful because it occurs so commonly in patients with congestive heart failure or auricular fibrillation. The thyroid gland may appear normal in size or insignificantly enlarged since hyperthyroidism in these patients is more apt to be associated with nodular goiter than with diffuse enlargement. The basal metabolic rate may be difficult to perform or evaluate in the presence of heart failure.

When the classic signs of hyperthyroidism are not apparent, it is nevertheless possible to suspect, if not actually to diagnose, hyperthyroidism on clinical grounds if it is considered in connection with certain definite findings. The occurrence of auricular fibrillation or of congestive heart failure in patients without definite underlying cardiac disease should in itself raise the question of hyperthyroidism. Loss of weight in the absence of anorexia in such cases should also lead to a consideration of associated hyperthyroidism. The tachycardia may be out of proportion to the degree of congestive heart failure. When there is a rapid ventricular rate in cases of auricular fibrillation, which does not slow as readily as is to be expected under management with digitalis, an associated hyperthyroidism should be suspected. If the circulation time is determined, the time will be found either to be rapid or normal in thyrocardiac disease with heart failure when in the usual cases of congestive heart failure a prolonged circulation time would have been ordinarily anticipated. Finally the lack of a satisfactory clinical response to appropriate treatment for heart failure should always lead to a search for masked hyperthyroidism. This applies also to cases of heart failure and auricular fibrillation with an apparent independent cardiac disease which could account for the failure or arrhythmia. For thyrocardiac disease commonly, if not invariably, occurs in the presence of clinically latent or overt heart disease, but control of the heart failure or auricular fibrillation is dependent on correction of the hyperthyroidism.

Presented at the Clinical Congress of the Connecticut State Medical Society, New Haven, September 11, 1951

OBJECTIVE TESTS OF HYPERTHYROIDISM

When the possibility of hyperthyroidism is considered or strongly suspected on the above mentioned clinical grounds, it is important to confirm this suspicion by some objective test. Despite its imperfections, the determination of the basal metabolic rate, when carefully performed, is still the simplest and most useful objective clinical test of hyperthyroidism. But in patients with thyrocardiac disease who suffer from severe congestive heart failure, the performance of the test may be difficult and evaluation of the result unreliable because of the patient's respiratory distress and the increased work associated with the muscles of respiration. The basal metabolic rate is commonly elevated in congestive heart failure without hyperthyroidism. Although the basal metabolic rate is often substantially more elevated in cases of congestive heart failure with hyperthyroidism than in heart failure due exclusively to independent heart disease, this distinction is not sufficiently sharp to permit a definitive differential diagnosis. On the other hand, in patients with thyrocardiac disease including auricular fibrillation but without heart failure, the reported basal metabolic rate is occasionally within normal limits or only slightly elevated. The accuracy of the diagnosis of hyperthyroidism in such cases is supported by the clinical response and lowered basal metabolic rate following antithyroid drugs, thyroidectomy or radioactive iodine.

Certain laboratory findings in cases of hyperthyroidism are of interest but cannot be used as decisive diagnostic tests. For example, it is generally true that the serum cholesterol level tends to be lower in cases of hyperthyroidism than in normal individuals. But the wide range of normal values reported, the considerable overlapping of serum cholesterol concentrations in hyperthyroid and euthyroid individuals, and the imperfect correlation between serum cholesterol and thyroid function invalidate serum cholesterol determination as a test of hyperthyroidism.[1,2] The creatine tolerance test has been studied more carefully in the past few years.[3] It has been determined that patients with hyperthyroidism in response to a 1 gm. load of creatine will reach higher serum creatine levels than normal individuals and the serum creatine concentrations are maintained above normal levels after a period of 135 to 180 minutes. However, this test is technically too complicated and has been insufficiently studied to be acceptable as a valid clinical test.

SERUM PRECIPITABLE IODINE

In recent years accuracy in the diagnosis of hyperthyroidism has been greatly enhanced by the determination of the serum precipitable iodine (protein-bound iodine) and by the response to the administration of a tracer dose of radioactive iodine (I^{131}). The determination of the serum precipitable iodine (SPI) offers a valuable and usually reliable means of diagnosing hyperthyroidism.[4,5] Its chief difficulty is the elaborate technic of the chemical procedure, which makes it unsuitable for routine clinical work except in large hospital laboratories. When the test is carefully performed, normal values between 4 and 8 micrograms per 100 cc. of serum are obtained. However, false high values may result not only during pregnancy but also if organic compounds of iodine are used, as in the performance of an intravenous pyelography or cholecystography, or if lipiodol is administered for diagnostic reasons.[6] Recent studies have shown that the serum precipitable iodine is increased also by the ingestion of inorganic iodides even when the patient has been receiving only therapeutic doses of Lugol's solution or potassium iodide.[7] On the other hand, the thyroxin fraction of the SPI, as determined by butanol extraction, is not elevated by the previous administration of inorganic iodides or Lugol's solution.[8]

RADIOACTIVE IODINE

More recently, quite satisfactory diagnostic results have been obtained with the aid of radioactive iodine. In general a tracer dose of 100 microcuries is given by mouth and studies are made of either (1) the excretion of radioactive iodine in the urine during the subsequent 24 hours,[9,10] (2) the serum precipitable (protein-bound) radioiodine in the blood after 72 hours,[11] (3) the radioiodine uptake by the thyroid gland,[12] or (4) determination of the extrarenal disposal rate from analysis of the curve of urinary radioiodine excretion and the serial serum I^{131} values.[13]

The excretion of less than 20 per cent of the administered dose of radioactive iodine is usually diagnostic of hyperthyroidism, i.e., there is a reduced iodine excretion because more than the usual amount is taken up by the thyroid gland and transformed into thyroid hormone. Excretion of 20 to 30 per cent of the radioiodine represents the overlapping range of normal and hyperthyroid individuals. In euthyroid patients, as a rule, 30 to 60 per cent of the administered radioiodine is excreted in a twenty-four hour period. This test suffers from

certain deficiencies, notably the need to collect carefully all the urine excreted within the test period, and false low values observed in cases of renal insufficiency or in cases of congestive heart failure associated with severe oliguria. Propylthiouracil must be discontinued for two to three weeks and iodides for one to two weeks before a satisfactory diagnostic test is made with I^{131}.

In the radiophysics laboratory of The Mount Sinai Hospital in New York, the determination of the protein-bound radioiodine following a tracer dose of this material has been found to be a reliable diagnostic test of hyperthyroidism, especially in conjunction with the determination of radioiodine excretion and serum precipitable iodine. Because there is considerable overlapping between the serum precipitable radioiodine levels in normal individuals and those of hyperthyroid patients 24 hours after the tracer dose, the determination is not made at this time. On the other hand, 72 hours after the administration of the tracer dose the serum precipitable (protein-bound) radioiodine is distinctly higher than the radioactive iodine level bound to protein in euthyroid individuals.[11] In practice, after the oral administration of a tracer dose of 100 microcuries of I^{131} all the urine is collected for 24 hours and the excretion determined, using 100 ml. aliquots and a calibrated Geiger-Müller counter. After 72 hours the level of radioactive iodine in the plasma is determined, with the aid of a counter of high sensitivity, such as the Q-gas counter. If there are less than 4 counts per second per ml. of plasma, the test shows normal values and no further investigation is made. If, however, there are more than 4 counts per second per ml. of plasma, the protein is precipitated with trichloracetic acid. The quantity of radioactive iodine in the nonprotein fraction is determined and subtracted from the counts per second per ml. in the whole plasma. The remainder represents the level of the radioactive iodine in the protein fraction. If this exceeds 4 counts per sec. per ml., the presence of hyperthyroidism is denoted. By studying both the SPI and the radioactive iodine level in the protein fraction it is believed that a diagnosis of hyperthyroidism can be made with a very high degree of accuracy. However, these objective tests should be interpreted with due regard for the clinical picture.

The value of these objective diagnostic procedures is indicated by the discovery of 8 cases of masked hyperthyroidism in a group of 55 patients with auricular fibrillation in whom hyperthyroidism was not previously suspected.[14] It had been assumed that the auricular fibrillation was due in five of these cases to arteriosclerotic or hypertensive heart disease, and in three to rheumatic heart disease. The accuracy of the diagnosis of hyperthyroidism was substantiated by reversion of the auricular fibrillation to normal sinus rhythm in six of the seven patients who were subjected to treatment with radioiodine. At the same time there was distinct clinical improvement in their cardiac status. Sinus rhythm was restored four to nine weeks after treatment. The one patient in this treated group in whom auricular fibrillation persisted suffered from longstanding rheumatic heart disease. These observations underline the admonition that the possibility of hyperthyroidism must be carefully investigated in all cases of auricular fibrillation.

Direct measurement of radioiodine uptake over the gland itself has thus far not proved to be a satisfactory test of hyperthyroidism because of the wide range of values. Perhaps the availability of new scintillation counters, which are 100 times more sensitive than the Geiger-Müller counter to gamma radiation, will enable us to use direct measurement of radioiodine uptake by the thyroid gland as an accurate test of thyroid function. Other advantages are promised by use of the scintillation counter. As little as 1 microcurie of radioiodine may be employed as the tracer dose, thus exposing the patient to no more radiation than from a routine chest x-ray examination, and permitting repeated tests. By means of the scintillation counter it may be possible to outline accurately the thyroid gland as a means of determining its weight, the latter being used as a major factor in determining the dosage of radioiodine for the treatment of hyperthyroidism.

Despite the high percentage of accuracy of the various objective tests of hyperthyroidism, there are still cases of thyrocardiac disease in which a definite diagnosis of hyperthyroidism cannot be made with certainty, or in which there is a discrepancy between the clinical findings and objective tests or between individual objective tests. In such cases it becomes necessary to do a therapeutic test. Formerly it was customary to administer 10 to 30 minims of Lugol's solution or more daily for a period of 2 weeks and then study the clinical response. If this was satisfactory, the diagnosis of hyperthyroidism was confirmed. Unfortunately, in my experience, this therapeutic test often gives equivocal results. Therefore I have found it much more satisfactory to administer

propylthiouracil for a period of 6 to 10 weeks as a rule. During this period the basal metabolic rate in cases of thyrocardiac disease has been sharply reduced, the pulse rate slowed and, most conclusively, the general clinical picture improved. This includes also a marked therapeutic responsiveness of congestive heart failure, which previously had been refractory to treatment.

Treatment of Thyrocardiac Disease

The treatment of thyrocardiac disease has undergone revolutionary change since the availability of the thiouracil antithyroid compounds and more particularly since the advent of radioactive iodine. The treatment of thyrocardiac disease, even in the presence of congestive heart failure, is essentially and primarily the treatment of hyperthyroidism. The congestive heart failure itself should be treated in the conventional way, but the results are so incomplete that this treatment is of minor importance compared to the elimination of the hyperthyroidism. On the other hand, when the hyperthyroidism is corrected, the hitherto most intractable congestive heart failure yields readily to simple treatment with rest, digitalization and, if necessary, low sodium diets and mercurial diuretics. Furthermore, as a rule the auricular fibrillation spontaneously reverts to regular sinus rhythm or occasionally is reverted by the administration of quinidine. In a small percentage of cases of thyrocardiac disease in which there is also advanced rheumatic or hypertensive and arteriosclerotic heart disease, auricular fibrillation may be due primarily to the organic heart disease independent of the hyperthyroidism. In such cases, auricular fibrillation will persist despite the cure of the hyperthyroidism.

subtotal thyroidectomy

The surgical procedure of subtotal thyroidectomy following some two weeks of iodine administration had reached a high degree of perfection prior to the availability of the antithyroid thiouracil drugs and radioiodine. The surgical mortality rate, in the most skilled hands was well under 1 per cent in patients with uncomplicated hyperthyroidism. This mortality rate was even further diminished by the use of propylthiouracil preoperatively to lower the basal metabolic rate to euthyroid levels, followed by a brief preoperative period of iodide administration. The excellence of this therapeutic procedure applies also to patients with thyrocardiac disease although the surgical risk is somewhat greater than in patients with hyperthyroidism. In a recent report based on 810 cases of hyperthyroidism, of which 103 (12.5 per cent) were thyrocardiacs, the operative mortality was 6.9 per cent among the thyrocardiacs as compared with 2.2 per cent for the noncardiac cases of hyperthyroidism.[15] These mortality rates apply to cases observed over a 20 year period. In addition to the mortality risk, however small, other disadvantages of the surgical procedure include possible injury to the vocal cords, the occasional production of hypoparathyroidism, a variable rate of recurrence of hyperthyroidism or production of postoperative myxedema and the expense and morbidity associated with a major surgical operation. Furthermore, there is always some hesitancy in subjecting a patient with congestive heart failure to major surgery.

radioactive iodine

The use of radioactive iodine (I^{131}) has led to significant advances not only in the diagnosis but also in the treatment of hyperthyroidism. Regardless of the low operative mortality rate associated with subtotal thyroidectomy, there is a distinct preference for a therapeutic agent which is equally curative at the same time that it avoids entirely the morbidity and mortality of the surgical operation. This applies with special emphasis to patients who have heart failure as well as hyperthyroidism. Furthermore, the treatment with radioiodine is extremely simple for in almost three quarters of the cases it involves only drinking the medication in a single dose. In the remaining patients, a second, third or rarely additional doses may be necessary after intervals of 6 weeks or more if a satisfactory clinical or basal metabolic response is not obtained.

The only contraindications to the use of radioiodine in thyrocardiac patients are pregnancy or the strong suspicion of operable thyroid carcinoma. The initial dose is dependent chiefly on the estimated size of the thyroid gland and to a much lesser extent on the percentage of uptake of the diagnostic tracer dose of radioiodine. In practice, the radiophysics group in charge of hyperthyroidism at The Mount Sinai Hospital, New York have been giving 1 millicurie (mc.) of I^{131} per 10 gm. of estimated thyroid weight, but usually a minimal initial dose of 5 mc.[16] A small gland usually weighs about 25 gm., a slightly enlarged gland 50 gm., while glands with patent goiters weigh 100 to 200 gm. The average initial administered dose in some 830 cases treated at The Mount Sinai Hospital until March, 1951, was 7 mc. Reported differences in the initial doses employed

by different groups of physicians probably depend chiefly on differences in standardization of the "millicurie" dose. An effort is made to undertreat the patient slightly with the initial dose. Clinical improvement usually appears in three to four weeks. If an inadequate reduction in basal metabolic rate is attained or if clinical improvement is unsatisfactory after 6 to 8 weeks the patient is given an additional dose which is smaller than the initial dose. This may be repeated after additional 8 week intervals until a satisfactory therapeutic response is obtained. With this schedule of treatment cure was obtained in 826 of 830 patients treated at The Mount Sinai Hospital. Myxedema has occurred in about 5 per cent of the patients, which is about the frequency or slightly less than the frequency of this complication following subtotal thyroidectomy. Some patients who appear mildly hypothyroid 6 to 8 weeks after the treatment dose of radioiodine are euthyroid after an additional 4 to 6 weeks. Therefore the diagnosis of myxedema is not substantiated until a more prolonged period of observation.

Certain modifications of treatment are made in cases of thyrocardiac disease. Patients with thyrocardiac disease are given Lugol's solution on the third day after the administration of the radioiodine and Lugolization is maintained for 3 or 4 weeks. It is then discontinued in order to evaluate the patient's clinical response to the radioiodine. Furthermore, thyrocardiac patients are given an initial dose which is about 20 per cent larger than that estimated as necessary according to the calculations mentioned above. This is done in order to assure a higher percentage of cures with the initial dose in patients with cardiac complications because of the more urgent necessity of a rapid therapeutic result.

Despite the obvious advantages of medical treatment with radioiodine over subtotal thyroidectomy, especially in cases of hyperthyroidism complicated by congestive heart failure, there are certain shortcomings and uncertainties which are attached to this medical form of therapy. The chief difficulty is the estimation of the dosage necessary to obtain a cure with a single dose. If an excessive dose is given, the danger of myxedema is increased. If the initial dose is inadequate, a relatively long period of delay will ensue before the hyperthyroidism is under control. This disadvantage may be serious in patients with auricular fibrillation and congestive heart failure but is partially obviated by the administration of Lugol's solution in the interval between the administration of the radioiodine and the evaluation of the response 6 to 8 weeks later.

Another difficulty concerns doubt as to the use of radioiodine in cases of hyperthyroidism due to toxic adenoma, even when its indication for the treatment of diffuse toxic goiter is accepted. The evidence that malignant neoplasms arise in adenomas and particularly in solitary nodules of the thyroid gland[17,18] raises constantly the question whether hyperthyroidism in such cases may not be associated with malignancy and therefore whether it is safe to depend on internal radiation with I^{131} instead of surgical excision. On the other hand, it is rare for the nodular goiter which becomes toxic to be the site of malignancy, and even then a hint of malignancy may be obtained by study of radioiodine uptake over the nodule, which may demonstrate that the nodule itself is nonfunctioning. In the occasional instances in which toxic adenoma is associated with malignancy it is possible that the administration of radioiodine, but in much larger doses than for benign hyperthyroidism, will be as effective a form of treatment as surgical removal. If the clinical condition of the patient suggests that medical treatment is much to be preferred for the hyperthyroidism even in a case of nodular goiter, then the clinical evaluation of the thyroid gland and study of radioiodine uptake by the nodule must be used as a guide to one's decision. After the hyperthyroidism and heart failure are controlled by radioactive iodine, any remaining doubts may be eliminated by performance of a biopsy, which is then a simple and safe procedure. The objection that radioiodine may result in carcinoma years after treatment is still theoretical and is less applicable to patients with thyrocardiac disease who are almost always past the age of fifty than to patients with uncomplicated hyperthyroidism who generally fall in younger age groups.

ANTITHYROID THIOURACIL COMPOUNDS

Although the thiouracil compounds have lost their central position of interest since the availability of radioactive iodine, they are widely used in the therapy of hyperthyroidism. Like radioiodine, the thiouracil compounds possess the advantages of a medical ambulant form of therapy. Furthermore, and perhaps most important at this time, propylthiouracil and similar compounds are readily available to the practising physician while radioiodine must be carefully administered under skilled supervision and its effectiveness must be tested in large

medical centers. The effectiveness of radioiodine is based on its destruction of the hyperplastic thyroid cells by radiation, while the effect of the thiouracil drug presumably is to interfere with the enzymatic processes within the thyroid gland which bind iodine to tyrosine in the process of forming thyroid hormone.

Propylthiouracil is the preparation most frequently used and is given orally in initial doses of 300 to 500 mg. daily, with reduction to 200 to 400 mg. after one to two weeks. This latter dose is then continued until the basal metabolic rate is reduced to normal levels and a satisfactory clinical response is obtained. Thereafter maintenance doses of 50 to 150 mg. per day are continued for 6 months to a year. Commonly Lugol's solution in doses of 1 to 5 minims daily is added to the regimen when clinical evidence of toxicity has been largely eliminated and the basal metabolic rate is below +20. The Lugol's solution is administered for 2 to 3 months after the propylthiouracil has been discontinued in an effort to normalize the thyroid gland, i.e., to reduce its size and vascularity.

Recently several newer antithyroid drugs have been employed. One of these, 1-methyl 2-mercapto imadazole (tapazole), has been recommended as a more potent and rapidly acting drug than the thiouracil compounds and as being relatively nontoxic.[19,20] This drug is given in much smaller doses than propylthiouracil, namely, 15 to 25 mg. a day until therapeutic control is obtained, followed by maintenance doses of 2 to 10 mg. daily. Another drug, 5-iodo 2-thiouracil, marketed commercially as itrumil, is a preparation which is available in 50 mg. tablets containing 23 mg. of iodine, 23 mg. of thiouracil and 4 mg. of sodium. The advantage of this drug is the presence of organic iodine incorporated in the molecule in order to make available not only the antithyroid effect of the uracil but also the antigoitrogenic effect of the iodine.[21] The initial daily dose is usually 300 to 400 mg. daily and this may be reduced when a satisfactory response has been obtained.

The wide usage of these drugs is indicated by the fact that about one-third of the 800 or more cases treated at the Mount Sinai Hospital with radioactive iodine had already received a course of one of the thiouracil compounds. When the thiouracil drug has been administered prior to the use of radioactive iodine, an interval of two or three weeks must elapse in order not to invalidate the diagnostic value of radioiodine and 4 or 5 days must elapse after discontinuing thiouracil drugs before treatment with radioactive iodine is begun. If itrumil is employed prior to radioiodine, it may interfere with I^{131} uptake by the thyroid gland for as long as two to four months. Hence this is not a satisfactory preparation to use in treatment if radioactive iodine is contemplated at a later date.

There are several disadvantages associated with the use of the thiouracil drugs. Relapse occurs in 50 per cent of the cases when treatment is discontinued.[22] Various toxic reactions have been noted repeatedly, although they are diminished in frequency with use of some of the newer thiouracil derivatives. However, we have observed very recently two fatalities from agranulocytosis associated with the use of propylthiouracil. Despite these toxic effects, thiouracil drugs still have an important usefulness as a preoperative drug when surgical intervention is contemplated as the primary form of treatment and when medical treatment is preferred but radioactive iodine is not readily available. It may be desirable in some cases to attempt to treat the hyperthyroidism with a thiouracil compound, while reserving radioactive iodine for that group of cases in which an effective result is not obtained or relapse occurs when the drug is discontinued. Finally, propylthiouracil is the drug of choice in patients with thyrocardiac disease in whom there is a discrepancy between the clinical picture and the objective test and a therapeutic trial is desirable for a more definitive diagnosis.

CONGESTIVE HEART FAILURE AND AURICULAR FIBRILLATION

It is apparent that the major treatment of heart failure and auricular fibrillation in thyrocardiac disease is the correction of the hyperthyroidism. However, the conventional measures for the treatment of these disturbances should also be instituted and are valuable adjuncts. Furthermore, in many patients rest, digitalis, low sodium diet and mercurial diuretics may be essential in order to control congestive heart failure and auricular fibrillation with rapid ventricular rate until the hyperthyroidism itself can be alleviated. In this connection it is important to emphasize that digitalis has a beneficial effect in thyrocardiac disease with heart failure and auricular fibrillation as it has in the treatment of these disturbances due to other causes. However, one should not anticipate slowing of the ventricular rate to normal so long as hyperthyroidism remains.

It is unnecessary in most cases to try to revert the auricular fibrillation to normal sinus rhythm. This occurs spontaneously within a few weeks after the hyperthyroidism is eliminated. However, when auricular fibrillation and a rapid ventricular rate are associated with congestive heart failure, digitalization to reduce the ventricular rate is indicated. If this is ineffective and the arrhythmia appears to be an important factor in maintaining the heart failure, quinidine should be administered in an effort to restore sinus rhythm. This may also be done preoperatively in cases in which a subtotal thyroidectomy is contemplated. Finally quinidine therapy may be instituted if the arrhythmia persists for more than one month after the hyperthyroidism is corrected.

SUMMARY

The problems in the diagnosis of hyperthyroidism when associated with auricular fibrillation and congestive heart failure have been discussed. Emphasis was placed on the value of serum precipitable iodine determinations and of tests following a tracer dose of radioactive iodine in order to discover the presence of hyperthyroidism in patients with auricular fibrillation and heart failure. The use of subtotal thyroidectomy, radioactive iodine and of the thiouracil antithyroid drugs in the treatment of thyrocardiac disease has been considered and their advantages and disadvantages enumerated.

BIBLIOGRAPHY

1. Peters, J. P., and Man, E. B.: Significance of serum cholesterol in thyroid disease, J. Clin. Investigation 29:1, 1950.

2. Bartels, E. C.: Basal metabolic rate and plasma cholesterol as aids in clinical study of thyroid disease, J. Clin. Endocrinol. 10:1126, 1950.

3. Peters, J. H., Schwartz, R., Mermelstein, H., Nefores, M. N., and Mansuy, M. M.: Studies of serum creatine tolerance. I. Findings in normal males and in hyperthyroidism, J. Clin. Investigation 30:799, 1951.

4. Kydd, D. M., Man, E. B., and Peters, J. P.: Concentration of precipitable iodine in serum, J. Clin. Investigation, 29:1033, 1950.

5. Starr, P., Petit, D. W., Chaney, A. L. et al: Clinical experience with blood protein-bound iodine determination as routine procedure, J. Clin. Endocrinol. 10:1237, 1950.

6. Man, E. B., and Peters, J. P.: Artifactual values of serum precipitable iodine, J. Lab. and Clin. Med. 35:280, 1950.

7. Danowski, T. S., Mateer, F., Weigand, F. A., Peters, J. H., and Greenman, J. H.: Serum iodine fractions in subjects receiving potassium iodide in small dosage, J. Clin. Endocrinol. 10:532, 1950.

8. Man, E. B., Kydd, D. M., and Peters, J. P.: Butanol-extractable iodine of serum, J. Clin. Investigation, 30:531, 1951.

9. Keating, F. R., Jr., Power, M. H., Berkson, J., and Haines, S. F.: The urinary excretion of radioiodine in various thyroid states, J. Clin. Investigation 26:1138, 1947.

10. Feitelberg, S., Kaunitz, P., Wasserman, L. R., and Yohalem, S. B.: The use of radioactive iodine in the diagnosis of thyroid disease, Am. J. M. Sc. 216:129, 1948.

11. Silver, S., and Fieber, M. H.: The blood levels of I^{131} after tracer doses in the diagnosis of hyperthyroidism, Proc. Soc. Exp. Biol. & Med. 1950; Am. J. Med. in press.

12. Werner, S. C., Hamilton, H. B., Leifer, E., Goodwin, L. D.: Appraisal of radioiodine trace technic as clinical procedure in diagnosis of thyroid disorders: uptake measurement directly over gland and note on use of thyrotropin (TSH), J. Clin. Endocrinol. 10:1054, 1950.

13. McConahey, W. M., Keating, F. R., Jr., and Power, M. H.: An estimation of the renal and extrarenal clearance of radioiodine in man, J. Clin. Investigation 30:778, 1951.

14. Bortin, M. M., Silver, S., and Yohalem, S. B.: Diagnosis of masked hyperthyroidism in cardiac patients with auricular fibrillation, Am. J. Med. 11:40, 1951.

15. Griswold, D., and Keating, J. H., Jr.: Cardiac dysfunction in hyperthyroidism, Am. Heart J. 38:813, 1949.

16. Feitelberg, S., Kaunitz, P., Silver, S., Simon, N., Wasserman, L. R., and Yohalem, S. B.: Hyperthyroidism, Arch. Int. Med. 85:471, 1950.

17. Cole, W. H., Slaughter, D. P., and Majarakis, J. D.: Carcinoma of the thyroid gland, Surg. Gynec. and Obst. 89:349, 1949.

18. Lahey, F. H., and Hare, H. F.: Malignancy in adenomas of the thyroid, J. A. M. A. 145:689, 1951.

19. Reveno, W. S., and Rosenbaum, H.: Treatment of hyperthyroidism, with 1-methyl 2-mercaptoimidazole, J. A. M. A. 143:1407, 1950.

20. McGavack, T. H.: The mode of action and clinical uses of antithyroid compounds, N. Y. State J. Med. 51:1729, 1951.

21. Gassner, F. X., Hopwood, M. L., Herrold, E. A., and Plummer, A. J.: Interpretation of goitrogenic properties of certain "antithyroid" agents, J. Clin. Endocrinol. 10:1485, 1950.

22. McCullagh, E. P., Humphrey, D. C., McGarvey, C. J., and Sundgren, V.: Results of propylthiouracil therapy for hyperthroidism, J. A. M. A. 147:106, 1951.

ARE VETERANS PEOPLE?

RICHARD WARREN, M.D., *Boston, Massachusetts*

The Author. *Associate Visiting Surgeon, Massachusetts General Hospital; Senior Consultant in Surgery, Veterans Administration Hospital, West Roxbury, Massachusetts*

HAVE you heard that "Socialized Medicine" is here to stay? It is true. The United States Government is building for use by the Veterans Administration 78 new hospitals to add to the 136 now in operation. This multimillion dollar venture, which will bring the total bed capacity of Veterans Administration Hospitals up to 143,000, is only a fraction of a tremendous building program which will allegedly be required to care for the estimated 300,000 veterans who will be sick by 1975. Such estimates, furthermore, are only on the basis of our current veterans population of 19,000,000 souls. Stable, indeed, would be the imagination which did not reel at the prospect of the further expansion which, if this policy is continued, will follow the Korean War and universal military service. Under present methods of interpreting eligibility laws the number of eligibles for care will eventually not fall far short of a figure which will include all the adult males, and many of the females, in the country, and so reach an order of magnitude of over 60,000,000.

Is this or is this not as it should be? Let us examine some of the issues involved. Disregarding for the moment the controversial moral question of what a country owes its veterans and considering only the practical sociological viewpoint, history has shown that unless veterans benefits are provided crime waves and revolutions follow major wars. As early as the days of the Gracchi, a century and a half before Christ, such benefits took the form of land grants. Octavius Caesar first made his reputation as an administrator by dealing tactfully with this problem in the early days of the Pax Romana. A thousand years after the fall of Rome when the pattern of strong central governments was again emerging from the dark ages, the problem once more arose. The defeat of the Spanish Armada was followed by the liberation from the armed forces into the population centers of England of a restless mass of unemployed and property-less individuals without training in civilian skills. There arose a crime wave of proportions which forced, in 1592, the passage in England of the first modern law arranging for invalid and widows pensions to be administered by a central government. Since that time federal bureaus to administer such laws have come into existence in all nations.

Looking at the historical record, therefore, no one will deny the necessity or desirability of veterans legislation. But in this country the degree to which it has expanded is absurd. During the Revolution invalid and widows' pensions were provided by the Continental Congress. This did not, however, satisfy the patriotic zeal of our ancestors, the soldiers of the Revolutionary Army. They demanded of Congress during the darkest days of that dark winter at Valley Forge half-pay for the rest of their lives following the cessation of hostilities on condition of service to the end of the War. When Congress demurred they declined to disband from convention until their wishes were granted. Congress perforce gave in, and well we may blush at the pattern which was thereby set for the motives which have stimulated subsequent veterans legislation, since they have been dictated by similar pressure groups rather than by sound social principles and true need. Not only death and disability (both that incurred in combat and otherwise) but the mere fact of service must be lavishly recognized. In 1931 and 1932 this country was spending more money on its veterans than England, France, and Germany combined although our manpower commitments in World War I were less

Reprinted by permission from Harvard Medical Alumni Bulletin, Vol. 25, No. 4, June 1951

than the combined total of those nations by a ratio of 1 to 7.

Surely the degree of this expansion is out of proportion to the will of the electorate. Indeed it is probable that most of the voters in the country are not aware of what is occurring. Let us consider for example the Medical Service of the Veterans Administration. If one excludes hospital construction the cost of this department is only between 5 and 10 per cent of total Veterans Administration expenditures. Yet, since most of the other activities of the Veterans Administration concern themselves with the allotment of funds in the form of pensions or educational (readjustment) benefits, the Medical Service represents the major activity of the Veterans Administration in terms of a dispensable service. Was it the intent of the people acting through the 74th Congress, which in 1935 passed Public Law 312, that all veterans who are ill from any cause at any time should be eligible for and receive free care? Surely not. The intent of that law was to use the empty beds then existing in veterans hospitals to relieve overloaded municipal and community hospitals of veterans who had long term illnesses or who were unable to pay for care. This was an expedient and beneficial measure. But the intent of the voters has been now so distorted by those responsible for hospital construction in the Veterans Administration that the good which was done tends to be undone by robbing civilian hospitals not only of multitudes of patients who are able to pay something towards a hospital bill or sickness insurance, but also of nurses, trained technicians, and other key personnel.

These Federal Hospital Builders have misrepresented the law by assuming, in effect, that all veterans are unable to pay for medical care and have raised their sights accordingly. To anyone working in a veterans hospital it is obvious that this assumption is incorrect. The majority of veterans hospitalized for non service connected disabilities (who make up more than two-thirds of the patient population of veterans hospitals at the present time) are active wage earners with responsible jobs. The political power of the Federal Hospital Builders has lain in the fact that they can show documentary evidence to back this false assumption. These documents are the papers which a veteran signs on admission to a hospital stating that he is unable to afford the care he is about to receive. Since neither he, nor the doctor nor anyone concerned can tell how much that care is going to cost and since the individual's private resources are never investigated nor his statements contested, the value of such a document is low.

Since World War II, thanks to men with vision (Bradley, Hawley, Cutler, and others), the standard of medical care in Veterans Administration Hospitals has been elevated to a high plane. This has been effected by soliciting and receiving the support of the medical schools and has thus in most cases also involved indirectly the civilian "teaching" hospitals connected with those schools since the staff of the one coincides with the faculty of the other. These bodies have participated in good faith. The future planned overexpansion will compromise that faith by operating to greatly restrict, if not to immobilize the activities of many of those very institutions. It is, indeed, not difficult to envisage the closing of certain of our big civilian teaching hospitals if and when the outlined Veterans Administration construction program is complete.

It is important to note that to date hospital construction planning has not been under the control nor even had access to the advice of the Veterans Administration Medical Service. Most employees of that Service, both administrative and professional, are opposed to further expansion. They realize that it would either dilute the quality of medical care which they can provide or seriously dislocate the civilian teaching hospitals which, with the medical schools, are the institutions upon which they in the last analysis depend.

In an attempt to present this subject without bias it is only fair to mention that there are certain advantages which some progressive sociologists think might accrue from the unlimited development of the program as outlined. If Socialized or Federalized Medicine is a good thing, as many such persons maintain, is not the Veterans Administration a clever device to demonstrate it to the American people who would otherwise balk at the stupendous decision which would be thrust upon them if suddenly asked to vote federalized medicine into being? Perhaps. Furthermore, there are aspects of the administration of care in Veterans Hospitals such as lack of competition among doctors, free consultation, lack of financial pressure to discharge prematurely patients who cannot pay, and others which are preferable to their counterparts in civilian hospitals. Again, granted. The important thing, however, is to put the pros and cons of this tremendous movement before the people rather than to masquerade further under the false banner of "nothing is too good for our dis-

abled boys." If there are those who think that this is what the nation wants it is but fair to call the program by its right name, "The United States Program of Free Federal Medical Service For All Adult Males." Then let them put it to Congress for a vote.

It is later than we think. It often happens that when the implications of a great movement such as this become clear it is so far advanced as to be difficult to stop. If the people do not want Free Federal Medical Service for all Adult Males, what is the practical alternative? Simply to stop building veterans hospitals now, and to alter or interpret the law so as to allow admission to current hospitals, in addition to all service connected disabilities, only to those non service connected cases who need long term care or who cannot afford medical insurance. There are good reasons why these two groups of non service connected veterans should be retained as eligible. The first is that exclusion of all non service connected veterans would limit the type of medical and surgical practice available to the highly trained doctors now serving in veterans hospitals and would so cause widespread resignations. The second reason is that many of the hospitals in the expanded building program are already built. It would indeed be a waste if due to a late awakening of the electorate, policies were so strongly reversed that these hospitals should stand empty. And finally let us recommend that future planning for Veterans Administration hospitals be placed in the hands of the Veterans Administration Medical Service and be based roughly on those potential segments of the veterans population which in the years to come will need long term care or will be unable to afford sickness insurance rather than on the total number of sick veterans regardless of circumstances. Such a policy instituted now would preserve a balance between civil and federal medical systems which would be beneficial to both. It would enable our present great veterans hospitals which have already had such an auspicious youth to continue to mature in personality and prestige.

160th ANNUAL MEETING
of the
Connecticut State Medical Society

Bulkeley High School, Hartford

April 29, 30, and May 1, 1952

PROGRAM COMMITTEE

John C. Leonard, *Hartford, Chairman*
Stevens J. Martin, *Hartford*
John F. Nolan, *Bridgeport*

LOCAL COMMITTEE ON ARRANGEMENTS

James R. Cullen, *Hartford*, Chairman

John F. Beakey, *Hartford* Thomas M. Feeney, *Hartford* Charles E. Jacobson, Jr., *Hartford*
W. Holbrook Lowell, Jr., *Hartford* Michael S. Zeman, *Hartford*

Preliminary Program

Tuesday, April 29

ANNUAL MEETING OF THE HOUSE OF DELEGATES

Brae Rafferty, *presiding*

10:00 Call to Order
Business Session

1:00 Luncheon for officers, members of the House and guests

2:00 Resumption of business

7:00 Annual Dinner of the Council

Wednesday, April 30

GENERAL PROGRAM

Auditorium of the High School

Brae Rafferty, *presiding*

9:15 Registration

9:45 Call to Order
Address of Welcome—President of the Hartford County Medical Association

10:00 The Prevention and Treatment of Diarrhea in Infants
Stuart S. Stevenson, *Research Professor of Pediatrics, University of Pittsburgh School of Medicine*

10:30 Current Problems in Antibiotic Therapy
Perrin H. Long, *Professor of Medicine, State University Medical Center at New York City*

11:00 Intermission to visit the technical exhibits

11:15 Coronary Heart Disease as a Problem in General Practice
Robert L. Levy, *Professor of Clinical Medicine, Columbia College of Physicians and Surgeons*

11:45 Modern Concepts of Hepatic Cirrhosis
John G. Mateer, *Chief, Division of Gastroenterology, Henry Ford Hospital, Detroit, Mich.*

12:30 Intermission to visit the technical exhibits

1:00 Luncheon, Cafeteria of the High School

2:00 Symposium on Indispensable Therapeutics
John C. Leonard, *presiding*
Robert L. Levy
Perrin H. Long
John G. Mateer
Stuart S. Stevenson

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

Section on Dermatology and Syphilology

Section on Gastroenterology

Section on Radiology

Connecticut Allergy Society

Connecticut Diabetes Association

Connecticut Association of Medical Record Librarians

Connecticut Branch, American Association of Medical Social Workers

Connecticut Society for Psychiatry and Neurology

Association of Connecticut Tumor Clinics

Hezekiah Beardsley Pediatric Club

Woman's Auxiliary to the Society

7:00 **Annual Dinner of the Society**
The Hartford Club—Guest: His Excellency John Lodge, *Governor of the State of Connecticut*

Thursday, May 1

GENERAL PROGRAM

Auditorium of the High School

Joseph H. Howard, *presiding*

9:30 Registration

10:00 Problems in Sterility
William J. Mulligan, *Assistant Obstetrician and Gynecologist, Harvard Medical School*

10:30 The General Practitioner as a Urologist
Elmer Hess, *Chief Urologist, St. Vincent's Hospital and Hamot Hospital, Erie, Pennsylvania; President, American Urological Association*

11:00 Intermission to visit the technical exhibits

11:15 Thromboembolism
Alton S. Ochsner, *William Henderson Professor of Surgery, Tulane University, New Orleans*

11:45 The Physician Looks at Murder
Richard Ford, *Medical Examiner for Suffolk County, Assistant Professor of Legal Medicine, Harvard Medical School*

12:30 Intermission to visit the technical exhibits

1:00 Luncheon, Cafeteria of the High School

2:00 Symposium on Peptic Ulcer (Arranged by Connecticut Society—American Board Surgeons)
Welles A. Standish, *presiding*
Participants to be announced in April Journal

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

Section on Anesthesia

Eye, Ear, Nose and Throat Section

Section on Obstetrics and Gynecology

Section on Orthopedics

Section on Physical Medicine

Section on Proctology

Section on Urology

Connecticut Chapter, American Academy of General Practitioners
Connecticut Rheumatism Foundation
(Joint Meeting)

Connecticut Chapter, American Physical Therapy Association

Connecticut Occupational Therapy Association

Association of Medical Examiners of Connecticut
Connecticut Society of Pathologists
(Joint Meeting)

Anesthesia Study Group

Complete information concerning the meetings of the Sections of the Society has not been received in time for publication in this issue of the Journal. These programs will be printed in the April issue.

Technical Exhibits — 1952 Annual Meeting

Space	*Firm*	*Location*
1	E. L. Washburn & Company, Inc.	New Haven, Conn.
2	Mead Johnson & Company	Evansville, Ind.
3	Burroughs Wellcome & Company (U. S. A.), Inc.	Tuckahoe, N. Y.
4	Denver Chemical Mfg. Company, Inc.	New York, N. Y.
5	Pet Milk Company	St. Louis, Mo.
6 and 7	Chesco—Connecticut Hospital Equipment & Supply Company (Division of G. Fox & Co.)	Hartford, Conn.
8	W. B. Saunders Company	Philadelphia, Pa.
9	Vanpelt & Brown, Inc.	Richmond, Va.
10	G. D. Searle & Company	Chicago, Ill.
11	C. B. Fleet Company, Inc.	Lynchburg, Va.
12	The Baker Laboratories, Inc.	Cleveland, Ohio
13	Lederle Laboratories Division, American Cyanamid Company	New York, N. Y.
14	U. S. Vitamin Corporation	New York, N. Y.
15 and 16	Surgeons & Physicians Supply Company	Boston, Mass.
17	Philip Morris & Company, Ltd., Inc.	New York, N. Y.
18 and 19	American Surgical Supply & Equipment Company	Bridgeport, Conn.
20 and 21	Professional Equipment Company	New Haven, Conn.
22	A. H. Robins Company, Inc.	Richmond, Va.
23	Ames Company, Inc.	Elkhart, Ind.
24	Doho Chemical Corporation	New York, N. Y.
25	Ayerst, McKenna & Harrison, Ltd.	New York, N. Y.
26	Spencer, Incorporated	New Haven, Conn.
27	Sandoz Chemical Works, Inc., Pharmaceutical Division	New York, N. Y.
28	Ciba Pharmaceutical Products, Inc.	Summit, N. J.
29	Wm. P. Poythress & Company, Inc.	Richmond, Va.
30	Smith, Kline & French Laboratories	Philadelphia, Pa.
31	E. F. Mahady Company	Boston, Mass.
32	Winthrop-Stearns, Inc.	New York, N. Y.
33	E. R. Squibb & Sons	New York, N. Y.
34	The Harrower Laboratory, Inc.	Jersey City, N. J.
35	Parke, Davis & Company	Detroit, Mich.
36 and 37	The D. G. Stoughton Company	Hartford, Conn.
38	Eli Lilly & Company	Indianapolis, Ind.
39	Vaisey-Bristol Shoe Company, Inc.	Rochester, N. Y.
40	Coca-Cola	
41	Desitin Chemical Company	Providence, R. I.
42	Nepera Chemical Company, Inc.	Yonkers, N. Y.
43	Varick Pharmacal Company, Inc. (Division of E. Fougera & Company, Inc.)	New York, N. Y.
44	Chas. Pfizer & Company, Inc.	Brooklyn, N. Y.
45	H. P. Hood & Sons	Boston, Mass.
46	Camel Cigarettes	New York, N. Y.
47	Pepperidge Farm, Inc.	Norwalk, Conn.
48	Saratoga Springs Authority	Saratoga Springs, N. Y.
49	H. J. Heinz Company	Pittsburgh, Pa.
50	Brewer & Company, Inc.	Worcester, Mass.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
BENJAMIN V. WHITE - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Medical Education and Medical Practice

Medical education is everybody's concern for within its sphere the health of the people has its most vital relationship. Such concern is one of deep significance for those social groups whose chief business it is to guard our health and administer to its needs. Those of the medical profession as acknowledged leaders in these groups obviously have a concern in medical education in order that their own ranks may be augmented with the best products possible and that their own need for continuing education may be satisfied to its highest capacity. Like all other education, medical education can never remain static; continuous progression is the only way to avoid mortification. Changes within its scope and policy is therefore ever to be welcomed and new methods and the discovery of vital needs ever must be sought.

The change from the earlier days of medical apprenticeship, first to the medical school as a separate institution and later to the teaching hospital represents a major revolution in teaching disciplines, a change in which wise educators properly have sought to keep the best of the old, to be added to the new. Nevertheless, this is not a simple task for times change, customs and living habits change, a whole national economy changes, health problems of a people change, and with such changes the concept of the modern hospital visualizes such an institution as a haven for every form of serious human illness. In wider concept the modern hospital can become a very center for the important aspects of all community health concerns. A hospital in such a commanding position obviously has a teaching responsibility extending beyond the training of doctors and nurses to that of other professional groups not necessarily ancillary to these but of primary importance in their own sphere of influence. The hospital-medical school combination which has for one primary purpose the training of young men and women for a career in medicine must recognize that the work of the vast majority of doctors is carried on to a great extent outside of such institutions. Further recognition must be given too, that in seeking the causes of many diseases all of the functioning processes of the body must be considered, including mental processes. Those concerned primarily with medical education therefore must sooner or later extend their vision to broader considerations of human adaptation to environment and to recognize that aberrations of such adaptation are primary causes of disfunction often expressed in disease processes. It should more and more be recognized that sick people in a hospital or in a dispensary in episodic illness may represent excellent teaching material but with limitations inherent in the isolation of such individuals from their environment. This is a recognition that many truly important aspects of family medical practice may be overlooked in a too rigid, mechanistic, analytic approach to diagnosis and treatment.

It is for this reason that some medical schools are attempting "new" ventures which send medical students into the offices of medical practitioners and into the homes of patients to learn at first hand the conditions and needs of medical practice outside of the teaching center. Some medical schools, too, are seeking further integration of the aspects of such medical practice into teaching programs to be taught

by those, other than medical specialists, who work in this field.

It is encouraging that some of those concerned with the responsibilities of medical education are extending their thinking to a consideration of the adequacy of the undergraduate training of the premedical student with a view to a mutual understanding with those devoted to this task of the real needs of the prospective doctor at this stage. The present isolation of the premedical student even in universities which maintain medical schools offers a fertile field for such bilateral consideration.

All of these changes in the view points of medical education are of concern to the practicing doctor because they embrace a wider recognition of the importance of his contribution to our national health. They are of concern to him because more and more his influence is bound to be felt in the processes of medical education. This increasing influence will be of benefit not only to our future doctors but it will enhance the continuous process of education which every doctor recognizes as a personal need for himself.

The Health-Needs Commission

The establishment by executive order of President Truman of a new commission to survey the health needs of the nation has become an increasingly controversial matter now that election campaigns are getting into more rapid stride. Many feel that the new health Commission may form a convenient hiding place for the compulsory health insurance question for those political advocates who may during this period prefer to tell the electorate that the matter is "under study." Prominent in the happenings since the announcement of the Commission has been the refusal of Dr. Gunnar Gunderson, a member of the Board of Trustees of the American Medical Association, to serve and the attack on the project by Dr. John W. Cline, president of the Association. Dr. Cline's viewpoint is that no emergency exists at the present time which should divert funds from defense needs, that the nation's health has never been better, that the life of the Commission (12 months) is inadequate to make such a survey and that other more comprehensive surveys are now being made by nonpolitical groups which will give results of highest value in depicting our national health needs. Dr. Cline in his statement made it clear that he was not attacking individual members serving on the Commission among whom "are to be found sincere and able men who have accepted the appointment with the finest intentions." He states, however, because of the short space of time that the Commission has been allowed for its work they will be ineffectual.

According to some commentators this shortness of time in itself should raise the suspicion that the new Commission is a political maneuver because but few conclusive results can be expected in the time allotment. Some idea of the scope of the Commission can be gained by the following: it is to study the current and prospective supply of medical, dental and nursing personnel; public health requirements; geographical distribution of health resources and facilities; medical research; and the adequacy of private and public programs designed to provide methods of financing medical care. This last item obviously brings into sharp delineation national insurance programs supported by payroll taxation.

Other viewpoints have been expressed by writers of medical opinion that a negative approach, i.e., that the health needs of the nation should not be studied, is not easy to support; particularly in considering the ability and integrity to be found in the personnel of the Commission. Our neighbor *New York Medicine* believes something is to be said for a middle ground, "the thought that the Commission on the Health Needs of the Nation should move swiftly to carry out the assigned task, the goal of discovering facts which will truly advance the health—not the politics—of the nation. The work of the Commission should be watched closely. If it allows itself to become a political football, Chairman Magnuson and its members should resign and tell the whole story."

It will be interesting to see as the campaign progresses how many candidates for public office who are known to favor compulsory health insurance at the national level will seek evasion of this issue on the grounds previously mentioned. The setback to former Senator Pepper's political ambitions in the last election is certainly not forgotten by such aspirants.

The Journal of the Student American Medical Association

The Student American Medical Association is now one year old and to mark this event in January 1952 appeared the first issue of the *Journal of the Student AMA*. It will be "a monthly publication designed to provide factual information and enlight-

enment on the scientific and socio-economic sides of medicine for the benefit of its 33,000 readers." It looks forward to participating in strengthening the student organization and portraying the enthusiasm of its members for their future careers.

The first issue appeared decked out in a striking bipartite cover of green and white. It reminds one a bit of some of the basket ball uniforms which bedeck our present collegiate players. Tom Gardiner has done a very commendable job securing advertising, with emphasis on books and surgical supplies. Dr. Austin Smith, editor of the *Journal of the AMA*, rightly presents the first guest editorial explaining the "why" of the new publication. A red sheet carries a Newsletter on "current significant developments" placed in the forefront of the *Journal*, and followed by *The Washington Wire* (Western Union take notice!), a double page highlighting medical legislation in Congress.

The three scientific articles cover three distinct fields of medicine, lung surgery, tuberculosis vaccine therapy, and kidney disease. Then follows an historical article on the Student AMA by the managing editor of the *Journal*, three articles featuring the University of Illinois College of Medicine, the American College of Radiology, and the American Heart Association, respectively. The distinguished editor of the *Oklahoma State Medical Journal* gives the students a brief and interesting sketch of Hippocrates. Two pages of cartoons and a letter of congratulations from President John W. Cline of the AMA complete the text.

The splash of colors is a bit overdone but youth loves color, so here it is. Advertisements in color, text captions, whole pages in feature articles—one closes the magazine with the expectation of finding our friend, Mead Johnson & Company, on the back cover with a rainbow border instead of a green, not the same green as adorns the front cover, however. One might well criticize the arrangement, or lack of arrangement, of colored advertising pages where such has necessitated in some cases three press runs. In the interest of economy a change in arrangement could have been effected so that by combining the same colors in signatures the expense of printing might have been appreciably reduced.

It is a good job nevertheless. We hope our medical students will read deeply within its covers and in doing so remember there is much to the practice of medicine in this latter half of the twentieth century beside drug therapy.

Are Veterans People?

Under this title Dr. Richard Warren points out that the present hospital program of the Veterans Administration may presage expansion to such proportions as to become a threat to the present system of civilian medical care. In viewing this situation the Committee on Veterans' Affairs of the Tennessee State Medical Association, headed by Dr. H. H. Shoulders, chairman, reports, "If this federal system can continue to draw upon our civilian system for skilled personnel, and draw upon the taxpayers for large sums of money, and continue an unchallenged campaign of publicity to build faith in the 'superiority' of this federal system, and destroy faith in the efficiency of our civilian system, it will not be very long until our civilian system is destroyed by a process of government encroachment."* This co-author recommends the adoption of a program by which veterans who are entitled to free service in government institutions can obtain the services they need for acute illnesses and injuries, at government expense, in our civilian system of medical care, preserving the right of veterans with chronic disability to admission to veterans' hospitals. Under such a program veterans' hospitals would hospitalize eligible veterans for: (a) Service connected disabilities, (b) Tuberculosis, (c) Mental illness, (d) Other forms of chronic illness which require hospitalization for more than ninety days, (e) Disabilities in dispute as to whether service connected or not. Dr. Warren's message is timely, for "It is later than we think."

The Red Cross

The 1952 Red Cross fund appeal comes at a time of continuing worldwide crisis that demands a great voluntary effort on the part of everyone since military strength alone cannot solve the problems created by this crisis.

Too many people take the millions of Red Cross workers and their humanitarian activities for granted. Each day volunteers in towns and cities throughout the country carry on a staggering program. Blood is collected and made available to the armed forces and to civilian hospitals; able-bodied and hospitalized servicemen and women are assisted in a thousand ways; disaster sufferers receive emergency care and shelter as well as long-term rehabilitation aid.

*Journal of the Tennessee State Medical Association, October, 1951.

Through less dramatic programs of service the Red Cross trains nurse's aides, home nurses, and first aiders, all of whom provide a foundation for civil defense—self help. The Red Cross gives children an opportunity to serve their community, nation and world; thus preparing them for the responsibilities of citizenship. In the fields of health and safety the Red Cross stands ready to give instruction, training, and information. Internationally, it helps to make the facilities and advantages of our country available to other countries and peoples in need.

The Red Cross has a far reaching effect upon the life of every American, especially during these uncertain times. Let's do our part to keep the services of the Red Cross geared to meet the needs of the nation and all its citizens.

Alcoholic Patients in General Hospitals

Alcoholics are sick people who need medical treatment. The general recognition of this fact is reflected in the establishment in recent years of special clinics, and treatment and rehabilitation programs in State institutions. The general hospitals more directly concerned with the care of these sick have been relatively slow in accepting a responsibility in the treatment of alcoholics. Nevertheless, it must be acknowledged that the acute illness of alcohol intoxication, like that of any other form of intoxication, needs proper medical care. It is in recognition of this type of thinking that some general hospitals are now providing beds for alcoholics, a policy which already has demonstrated that the alcoholic is a suitable patient and benefits from hospital treatment. L. C. French of the Knickerbocker Hospital (New York City) reports on a four year experience of an 18 bed pavilion for alcoholics, that the care of these patients does not interfere with other hospital services, does not constitute a great nursing problem, the service is less expensive to run than a comparable surgical or medical service, and the ward was easily integrated with other teaching services. Hospitalization of this character, it has been also pointed out, gives an excellent opportunity for the start of rehabilitation programs, through individual and group therapy services and cooperation with agencies, such as Alcoholics Anonymous, outside the hospital.

The County Medical Society

The importance of the county medical society as the grass roots unit of the AMA is generally recognized and its potentialities as an important functioning organization within its own confines is more and more becoming realized. Witness to the latter is seen in the recent appointment of a full time executive secretary for one county group within the State and the establishment of an adequate part time salary for the secretary of another. Increase in the activities of county societies of more recent date has included development of emergency call systems within the area, establishment of committees to hear and settle patient complaints, development of better relations with press and radio, aiding the Woman's Auxiliary, and encouraging members to take active roles in health campaigns.

However important these increased activities are, if they are to be effectual in strengthening the county society, they must have the support of the individual members. Officers and boards of control must look for guidance and instruction from those whom they represent. Therefore, the importance of the business affairs of the county society as they are deliberated at regular meetings is paramount. Attendance at county meetings is a real part of good medical citizenship.

The Committee on Foods, Drugs, Cosmetics, and Devices

An activity in which the Connecticut State Society has important responsibility is that of being represented on the above named Connecticut committee. Sponsoring societies and institutions which have similar representation include the Connecticut Agricultural Experiment Station, Connecticut Parmaceutical Association, Connecticut Veterinary Medical Association, Connecticut State Dental Association, University of Connecticut, University of Connecticut College of Pharmacy, and Yale University School of Medicine. Other agencies which have ex officio representation include: the State Pharmacy Commission, State Department of Health, the Food and Drug Commission. The Connecticut State Medical Society is represented in the member societies by Dr. Hugh L. Dwyer. Dr. William T. Salter represents the Yale School of Medicine.

Francis Gilman Blake

The editors of the JOURNAL record their deep sense of personal loss in the death of Dr. Francis G. Blake. Dr. Blake exemplified in life the highest tradition in American Medicine and his outstanding contributions will remain as an enduring monument to his memory. As Professor of Medicine and Dean at the Yale School of Medicine he was closely associated with many interests of the Connecticut State Medical Society. No call for his services in behalf of the Society ever went unanswered. On many occasions in war and peace times his widely recognized knowledge and skill as a physician carried him abroad even to far corners of the globe. It was highly fitting that the Nation should honor his final resting place. The far greater part of his professional life was spent, however, with us and we shall do honor to ourselves in claiming him ever among the great of Connecticut doctors.

Psychosomatic Medicine

From an editorial in British Medical Journal

Psychosomatic medicine essentially is not a specialty but a point of view, and an approach which applies equally to medical and surgical problems. It is basic medicine which has needed re-emphasis. The compassionate aspect of medicine has perhaps been rather overshadowed by the rapid growth of techniques of investigation and by the present abundance of specific remedies. The best physicians and surgeons have long regarded their patients as individuals with backgrounds which may influence their illnesses. Some medical men, because they have been too hurried or too poorly trained, may have tended to think only in terms of the immediate disease process and have not had a sympathetic understanding of the patient's problems. There is no doubt that many patients benefit merely from the taking of a detailed history at leisure and in privacy, and the unburdening of their story, often untold to others, may save many weeks of attendances at outpatient departments or surgeries. But "psychosomatic" is an unnecessary term, and the sooner it is dropped from the current literature the better.

The Full-Time Employment of Physicians in Connecticut

CREIGHTON BARKER, M.D., *New Haven*

About one year ago an analysis of the record of the Connecticut Medical Examining Board was made to determine the sources and dispersal of physicians obtaining licenses to practice medicine in Connecticut.* That study disclosed the unexpected fact that nearly 25 per cent of the new physicians locating permanently in Connecticut during the years 1945-1949 inclusive, entered full-time employment of one kind or another and did not engage in the practice of medicine as it is usually defined.

While it may be reasonably assumed that this state of affairs in Connecticut may not be typical of the country as a whole, importance must be attached to the increasing demands for physicians in full-time employment as it relates to the overall production of physicians by the medical schools. Not many years ago, it was safe to say that all but a small percentage of medical graduates entered the practice of medicine and took care of the sick and perhaps it is not fully realized how far the trend of full-time employment has reached and if the Connecticut experience can be used as a criterion, twenty to twenty-five per cent of physicians graduated will not engage in the care of sick individuals.

The present study had, as its objectives, the determinations of the number of physicians in full-time employment in Connecticut and the types of employment. Only those physicians who are in full-time salaried positions are included, anesthesiologists, radiologists and others operating on a commission or "shares" basis are considered to be independent contractors and are not included in this tabulation. Interns, residents and research fellows are omitted.

1. Medical school teaching (this is a group classification and not separated into specialties)	95
2. Veterans care	63
3. Public health	43
4. Private mental hospitals	39
5. Tuberculosis hospitals	39
6. Public mental hospitals	38
7. Insurance	34
8. Industrial medicine	26

*Where Do Doctors Come From? Creighton Barker, M.D., Walter L. Johnson, M.A., Robert Straus, PH.D., Federation Bulletin, March 1951.

9. Anesthesiology	24
10. Pathology	21
11. Radiology	16
12. State schools	9
13. University and school health	8
14. Miscellaneous	7
15. Administration	5
16. Physical medicine	2

This is a total of 426 physicians or a little less than 20 per cent of the number of physicians actually engaged in medical occupation in the State. In other words about one physician in six in Connecticut is occupied with full-time medical pursuits and not in practice.

The inquiry also included a question as to how many more physicians would be required to fill all of the full-time positions. This answer is not as reliable as the other finding, because the first is a matter of fact and this may be a matter of wish, but in any case, according to the results of this study 64 more physicians are needed to fill reported vacancies exclusive of medical teaching positions.

Dr. Braceland Honored

The consulting and courtesy staffs and the Board of Directors of the Institute of Living sponsored a dinner on January 31 for Francis J. Braceland, newly appointed psychiatrist-in-chief at the Institute. Over 350 physicians of Connecticut attended the dinner at the Hartford Club and in addition to many of Connecticut's leading psychiatrists, there were present four national leaders in this field. Leo Bartemeier of Detroit, president of the American Psychiatric Association; Houston Merritt of New York City, president of the Association for Research in Nervous and Mental Disease; S. Bernard Wortis of New York City, president of the American Neurological Association; Daniel Blain of Washington, D. C., medical director of the American Psychiatric Association—all were present to bear tribute to Dr. Braceland's outstanding qualities as a leader in psychiatry. In addition, Staunton Williams of Hartford, president of the Institute, assured those present that the hospital will render continued service to Hartford, and Thomas P. Murdock of Meriden, chairman of the Board of Medical Visitors, emphasized the fitting qualities possessed by Dr. Braceland for his new position.

Dr. Braceland's own remarks were brief, fitting, and much to the point. He paid due tribute to Mr. Williams, General Wadhams, and Dr. Von Salzen. The latter particularly for his effective guidance of affairs at the Institute following Dr. Burlingame's death. He stressed the four aims of the Institute: to take the best possible scientific care of its patients; to train young men and women; to conduct psychiatric research; and to make its contribution to medical progress in Hartford and in Connecticut. He bespoke the good will and active interest of the physicians of the State in the Institute, particularly at this time when practical expressions of interest are so necessary.

Creighton Barker, executive secretary of the State Medical Society and a member of the Board of Medical Visitors at the Institute, acted as toastmaster. A moment of silence in memory of the late Dr. C. C. Burlingame followed the dinner.

Connecticut Heart Association Grants

Four research grants totaling $2,650 have been made by the Research Committee of the Connecticut Heart Association. These grants are in addition to the $10,200 which was allocated for seven projects last June from funds raised during the 1951 Heart Drive. Three of the four grants made recently are being supported by a special gift to the Greenwich Health Association which represents the Connecticut Heart Association in that community.

The four grants are as follows:

1. To Dr. Max G. Carter, New Haven, for research directed toward developing of surgical technique for correcting mitral insufficiency—$400.

2. To Dr. Ruth Whittemore, for the further development of angiocardiography as applied particularly to infants and small children—$150.

3. To Dr. William Salter, to supplement an earlier grant for the continuation of a study of the effects of radio-active iodine in the management of thyrocardiac patients and in cardiac patients with normal thyroid function—$600.

4. To Dr. John Paul, and his associate Dr. S. J. Liao for continuing research on the immunological aspects of rheumatic fever designed to improve laboratory methods for the diagnosis of acute rheumatic fever and its differentiation from allied diseases—$1,500.

The last three projects listed will be carried on at the Yale University School of Medicine.

PROGRESS IN CLINICAL MEDICINE

TUBERCULOUS PLEURISY WITH EFFUSION ITS SIGNIFICANCE AND MANAGEMENT

C. P. LeRoyer, Jr., M.D., *Beverly, Massachusetts*

Tuberculous pleurisy with effusion is only one manifestation of tuberculous infection. It is usually unilateral, ocassionally alternating, and rarely simultaneously bilateral. It may or may not be associated with demonstrable parenchymal disease.

Some observers state that all "so-called" idiopathic pleural effusions should be considered tuberculous. That is a very healthy attitude for all physicians to assume because pleural effusion is a serious phase of tuberculosis and is frequently the result of hematogenous spread of the infection. All too often the "mild" case of pleurisy with effusion is assumed to be due to a cold or some acute infection, and forgotten about as soon as the pain and fever have subsided. There is no such thing as a slight attack of tuberculous pleurisy. It is just such a case who several years later is admitted to a sanatorium with advanced pulmonary disease. The history is obtained from the patient that, "Oh, yes, I had pleurisy several years ago, but it cleared right up." Only at admission is this incident given the significance it should have received at the time it occurred. If proper treatment had been carried out, he would have had a 70-80 per cent chance of never developing parenchymal disease; without bed rest he fell into the group of 70-80 per cent who develop pulmonary tuberculosis in 2-5 years.

It is a fortunate patient whose tuberculosis is ushered in by pleurisy rather than by an hemoptysis because the latter usually indicates advanced pulmonary disease often with a contralateral spread and will require prolonged sanatorium care, whereas the former usually responds very well to a few months bed rest. Therefore, it is most important to treat pleurisy as a serious matter and not just as a "cold."

Many physicians are being lulled into a false sense of security concerning tuberculosis by declining mortality rates and the clinically unproved claims for BCG vaccination.[1] They fail to realize that there are now close to one million individuals in the United States alone and probably one hundred million in the world who harbor living virulent tubercle bacilli. Thus it will be many decades before tuberculosis is wiped out.[2] It is the first of all diseases as a cause of incapacity and death among the peoples of the world as a whole.[1] It must be reemphasized that tuberculosis is prevalent, but it is also preventable. The case of tuberculous pleurisy with effusion already has a tuberculous infection but, if recognized early and adequately treated, it can be prevented from progressing to advanced pulmonary disease.

PATHOGENESIS

Miller[3] has shown by his exhaustive study of the lung that the visceral pleura receives its blood supply from the bronchial arteries and the sub-pleural parenchyma from the pulmonary artery. The transitional or sub-pleural zone is the usual site for tubercle development. Rubin[4] feels that the tubercle bacillus may arrive in this area as a result of hematogenous spread through the bronchial arteries or the pulmonary artery, or by way of the sub-pleural or deep (parenchymal) lymphatics. He feels that simultaneously bilateral effusions and alternating effusions are due to a hematogenous spread, but that a unilateral effusion is usually due to a lymphatic spread. Bird[5] also indicates his belief that hematogenous spread is the most likely pathogenesis in alternating pleurisy with effusion. Tuberculous bacillemia is more frequent than appreciated[6] and death from miliary tuberculosis is seen in a certain percentage of cases of bilateral and alternating pleural effusions.[7]

Paine[8] reviewed 45 cases of bilateral effusion (alternating), and he is of the opinion that these cases resulted from a hematogenous and not infre-

quently from a general miliary spread of the tubercle bacillus. In Sibley's[9] series of 200 cases of pleurisy with effusion almost 20 per cent developed extra-pulmonary tuberculous lesions, hematogenous in origin. Thus, it would appear that pleurisy with effusion may often by the immediate result of a hematogenous infection of which the extra-pulmonary lesions are also a part, but which become manifest subsequent to the pleural effusion, often only after the patient is up and back at work.

It would seem that there are two valid explanations for the development of pleural effusion, hematogenous and lymphatic; a large percentage of these cases can be assumed to result from a hematogenous spread. The problem of the allergic responses of the pleura to the tubercle bacillus as a factor in the development of pleurisy with effusion is real. A full discussion of this factor is not possible in this communication.

DIAGNOSIS

Serofibrinous pleurisy is usually acute but may be insidious in onset. It is more often seen in the young adult, but today more and more tuberculous pleurisy with effusion without parenchymal disease is seen in people over fifty. Malaise, fever, cough, pain, and dyspnea are common symptoms; night sweats may often be noted. The effusion may be large and discovered by physical examination, or minimal and found only by chest x-ray. The tuberculin skin test should always be done, and it is usually positive. But, if the pleural effusion is part of an overwhelming miliary disease, it may be negative.

Diagnostic aspiration of the pleural fluid is indicated, and all the fluid that can be obtained, not just a few cubic centimeters, should be sent for culture and guinea pig studies. It has been shown that the more fluid that is "spun down," the more likely the tubercle bacillus will be recovered. If 100 cubic centimeters or more is used, 60 to 80 per cent positive cultures will be obtained. A negative guinea pig or culture, however, does not exclude tuberculous infection.

The fluid is usually clear and straw colored, but Berliner[10] found that it may occasionally be hemorrhagic. Of 113 cases of hemorrhagic pleural effusion, he found 8 were due to tuberculosis. The lymphocyte is the predominate cell.

Aspiration of gastric contents should also be done for guinea pig inoculation because occasionally this will be positive even when there is no parenchymal lesion demonstrable by chest x-ray.

TREATMENT

Patients with active pulmonary tuberculosis require a sanatorium regime. For the patient with pleurisy with effusion this should be for four to eight months depending upon the response to bed rest. Clinically, the acute phase of the disease is over in four to six weeks, but the tuberculous process is still active and ready to explode. The patient must be educated to realize this so that he will accept the regimen.

Management of the pleural fluid is a controversial subject. Some phthisiologists feel only diagnostic aspirations should be done, others that the pleural space should be kept as dry as possible. It seems reasonable to aspirate as often as necessary to keep the fluid at least below the level of the top of the diaphragm in order to prevent the development of extensive loculations and fibrothorax. Pulmonary function is greatly impaired by pleural fibrosis, and it would seem sound to try to prevent this reaction by keeping the pleural fluid as low as possible.

Because pleural effusion may be the result of hematogenous tuberculosis, the use of streptomycin would appear to be valuable. However, the drug is usually withheld, and wisely so, for the development of complications. There will be instances when it should be used, and each case must be evaluated on its own merits.

Proper management of these cases should include regular follow-up chest x-rays every six months for at least five years. Only in this way will early, silent parenchymal lesions be discovered before they have progressed.

PROGNOSIS

The age of the patient at the time of the pleural effusion has been shown by some observers[8,9,11] to have little influence on the subsequent development of parenchymal tuberculosis. The size of the effusion and the side involved apparently have no direct bearing on the complications to be met or on the prognosis.[9]

Paine[8] noted that there is a direct relationship between the development of pulmonary tuberculosis, in two to five years, and the length of sanatorium care for cases with bilateral and alternating effusions. The longer the treatment, the fewer patients will develop pulmonary tuberculosis. Thompson[11] had 190 cases of pleurisy with effusion and no parenchymal disease; 40, or 22 per cent, developed parenchymal disease, 20 cases developing their lesions within the first year.

In Trudeau's[12] series there were 54 cases of pleurisy with effusion and no demonstrable parenchymal disease. They had an average sanatorium stay of four months. Three relapsed, one each after one, five, and seven years respectively. It must be noted that this excellent result is reflected in great measure by the fact that these patients were in the higher income groups. In contrast with this result Farber's[13] review of 111 cases, followed three to thirteen years, revealed a 30 to 40 per cent relapse rate. The majority of his cases were in the lower income groups. These observations reemphasize the importance of the income status of the tuberculous patient to adequate prolonged care and a low relapse rate.

CONCLUSIONS

1. Tuberculosis is still a prevalent but preventable disease.

2. Tuberculous pleurisy with effusion is a serious manifestation of tuberculous infection because it is often a result of a hematogenous spread of tubercle bacilli. Simultaneously bilateral and alternating pleurisy with effusions carry a much graver prognosis than unilateral pleurisy with effusion.

3. Negative bacteriology of the pleural fluid does not exclude tuberculous infection, and all "so-called" idiopathic pleural effusions should be considered tuberculous.

4. Proper management demands a sanatorium regimen for four to eight months. Diagnostic aspiration of chest fluid is indicated, and repeated aspirations requisite in certain cases. Streptomycin should be withheld for serious complications. Continued follow-up of cases every six months for five years is necessary for continued cures.

BIBLIOGRAPHY

1. Myers, J. Arthur: Immunity in Tuberculosis. J. A. M. A. 146:1492 (August 18) 1951.

2. Dubos, René J.: Biological and Sociological Aspects of Tuberculosis. Bull. of the N. Y. Acad. of Med. 27:351 (June) 1951.

3. Miller, W. S.: The Lung. Charles C. Thomas, Springfield, Ill., 1950.

4. Rubin, Eli H.: Hematogenous Tuberculosis in the Adult. I General. Am. Rev. Tbc. 39:557 (May) 1939.

5. Bird, K. T.: Alternating Pleurisy with Effusion as a Manifestation of Tuberculosis: A Report of Seven Cases. N. E. J. M. 234:491 (April) 1946.

6. Wilson, G. S.: Tuberculous Bacillemia. Med. Rev. Coun. Spec. Rep. Series. No. 182, London, 1933. 146 pp.

7. Gray, J. W.: Bilateral Effusions followed by Miliary Tuberculosis of Lungs and Tuberculous Meningitis. Lancet. 1:75: 40.

8. Paine, A. L.: Bilateral Tuberculous Pleurisy with Effusion. Am. Rev. Tbc. 44:424 (October) 1941.

9. Sibley, John C.: A Study of 200 Cases of Tuberculous Pleurisy with Effusion. Am. Rev. Tbc. 62:314 (September) 1950.

10. Berliner, Kurt: Hemorrhagic Pleural Effusion: Analysis of 120 Cases. Ann. Int. Med. 14:2266, 1941.

11. Thompson, B. C.: Prognosis of Primary Pleurisy with Effusion. Br. Med. J. 1:487 (April) 1947.

12. Trudeau, F. B.: Pleural Effusion: Its Prognosis in Patients Showing Little or No Parenchymal Involvement. Am. Rev. Tbc. 39: 57 (January) 1939.

13. Farber, J. E.: Prognosis in Cases of Serofibrinous Pleurisy. N. E. J. M. 228:784 (June. 17) 1943.

Health Problems of Workers Considered

Various problems concerned with the physical welfare of the nation's industrial workers were considered at the Twelfth Annual Congress on Industrial Health held in Pittsburgh in January. Benjamin V. White of Hartford participated in the program. Considered were the relationship of the housewife to the industrial situation, the requirements of an increased labor force for defense production, and the responsibility of labor, management and medicine for the health of the American worker.

A joint conference of the Council on Industrial Health and the chairman of State committees on industrial health was held on the day prior to the opening of the Congress. At that meeting industrial health experiences in Pennsylvania were related by physicians from all over the State.

Yale Physician Receives Citation

Five women physicians on January 20 received the fourth annual Dr. Elizabeth Blackwell citations for outstanding work in the field of medicine. They were Ethel C. Dunham, associate professor emeritus of clinical pediatrics at Yale University School of Medicine; Edith L. Potter, associate professor of pathology in the Department of Obstetrics and Gynecology, University of Chicago; Martha M. Eliot of the U. S. Children's Bureau; Annie J. Scott of New York; and Catherine McFarlane of Philadelphia.

Dr. Dunham won her citation for achievement in the study and improved care of premature infants.

THE PRESIDENT'S PAGE

No Doctor of Medicine would deliberately do anything to cause harm to a patient. Certainly the average physician, if so accused, would unhesitatingly and properly deny the charge; for considering the traditions of his profession, to say nothing of the practical consequences of such an action, it is unthinkable that a physician could or would do this.

Yet it may be true that in his daily, humdrum routine of prescribing the physician does unintentional harm at some time. The mere matter of prescribing too often, or too much, may become unconsciously a habit. If it is true that some practitioners have a tendency toward a punch card type of response, then a specific diagnosis automatically brings certain drugs to attention and so the patient with that diagnosis is in some danger of getting all the drugs associated with that particular diagnosis, regardless of their clearcut indications, their practicability, or their usefulness.

Perhaps more real is the danger of the recurring routine of prescribing sleeping pills and narcotics. Regarding narcotics there are a number of pertinent and thorough laws and the effects of the drugs are both dramatic and acute, so their misuse in general is not too widespread. But the prescribing of sleeping pills is so common throughout the profession that it is reliably estimated that a full 20 per cent of all prescriptions are for barbiturates. The peril from this lies in the habit of giving the drugs too frequently and too long by routine, for in their perpetual use addiction arises.

The difference between therapeutic use and addiction is wide, and in that width comes a danger. Again, the effects of these drugs are not as dramatic and acute as those which are commonly accepted as narcotics and therein lies the second danger, the addiction is not suspected and recognized until it is fully developed after a period of long standing. For these reasons addiction is doubly difficult to undo.

We are not here concerned with the tricks whereby patients exploit busy practitioners and druggists to accumulate stocks of drugs for suicidal purposes. If the physician were to be more conservative in his prescribing habits and the druggist more strict in his observing the present laws, these experiences would undoubtedly diminish to a minimum. But we should be aware that we can be lured into error by too complaisant habits in our prescribing.

Brae Rafferty, M.D.

CONNECTICUT CANCER CONFERENCE FOR PHYSICIANS

Sponsored by

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

CONNECTICUT CANCER SOCIETY

CONNECTICUT STATE MEDICAL SOCIETY

CONNECTICUT STATE DEPARTMENT OF HEALTH

Hotel Taft, New Haven

Wednesday, March 19, 1:15 to 5:45 P. M.

PROGRAM

Brae Rafferty, M.D., *presiding*

1:15 REGISTRATION

1:45 THE THERAPY OF MALIGNANCY IN CHILDHOOD
Nicholas M. Stahl, M.D., Children's Hospital, Boston

2:30 CARCINOMA OF THE STOMACH — CLINICAL CONSIDERATIONS
William A. Cooper, M.D., New York Hospital-Cornell Medical Center

3:00 CARCINOMA OF THE STOMACH — RADIOLOGICAL DIAGNOSIS
Sydney Weintraub, M.D., New York Hospital-Cornell Medical Center

3:30 CYTOLOGICAL DIAGNOSIS OF CARCINOMA OF THE STOMACH — Motion Picture
George Papanicolaou, M.D. and William A. Cooper, M.D., Cornell University Medical College

4:15 INTERMISSION

4:30 ENVIRONMENTAL CARCINOGENESIS
W. C. Hueper, M.D., National Cancer Institute, Bethesda, Maryland

5:15 THE PROBLEM OF PIGMENTED MOLES AND MALIGNANT MELANOMA
George T. Pack, M.D., Memorial Cancer Center, New York

5:45 SOCIAL HOUR

ANNUAL COUNTY ASSOCIATION MEETINGS

New Haven, Thursday, March 27

HOTEL ELTON, 30 WEST MAIN STREET, WATERBURY

Business meeting 4:30 P. M.

Speaker: Dr. Konrad Birkhaug, Principal Medical Bacteriologist in the New York State Department of Health

Subject: "THE WORLD HEALTH ORGANIZATION'S INTERNATIONAL CRUSADE AGAINST TUBERCULOSIS"

Hartford, Tuesday, April 1

HARTFORD CLUB

Business meeting 4:30 P. M. Dinner: 7:00 P. M.

Social Hour 6:30 P. M. Speaker and subject to be announced

New London, Thursday, April 3

SEASIDE SANATORIUM, WATERFORD

Business meeting 4:30 P. M. Speaker and subject to be announced

Fairfield, Tuesday, April 8

STRATFIELD HOTEL, BRIDGEPORT

Business meeting 4:30 P. M. Dinner 7:00 P. M.

Speaker: Alex Raymond

Subject: "SIGNIFICANCE OF THE COMIC STRIP IN TODAY'S SOCIETY"

Middlesex, Thursday, April 10

COMMODORE MACDONOUGH INN, MIDDLETOWN

Business meeting 4:30 P. M. Speaker and subject to be announced

Tolland, Tuesday, April 15

OLD HOMESTEAD INN, SOMERS

Dinner 6:30 P. M. Business meeting 8:30 P. M.

Speaker and subject to be announced

Windham, Thursday, April 17

WILLIMANTIC

Speaker and subject to be announced

Litchfield, Tuesday, April 22

Speaker and subject to be announced

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

The Council Meeting

A regular meeting of the Council was held on Thursday, January 17, at the Society offices in New Haven. There were present: Drs. Bishop, Couch, Danaher, Fincke, Gettings, Gibson, Howard, Labensky, Murdock, Parmelee, Phillips, Rafferty, Root, Tracy, Walker, Weld, Whalen, Barker. Absent: Drs. Gallivan, Gilman, Squillante, Thoms, Ursone. The meeting was preceded by the first meeting of the 1952 Nominating Committee.

CLINICAL CONGRESS

Dr. Bishop presented a report of the special subcommittee that had been appointed to study the operation and future policies of the Connecticut Clinical Congress. It was voted to hold the Congress as usual in 1952, probably with a two day program and certain other changes as recommended by the special subcommittee.

PROCEEDINGS OF THE HOUSE OF DELEGATES

It was voted that verbatim minutes of the House of Delegates would not be published in the JOURNAL in the future.

CONFERENCE OF CONNECTICUT ASSOCIATION OFFICERS

It was voted to hold the annual Conference of County Association Officers in New Haven on March 20, and the secretary was authorized to arrange the program and make the necessary expenditures.

CONNECTICUT HOSPITAL SERVICE

Thomas J. Danaher, Edward H. Truex, Jr., and Creighton Barker were appointed to succeed themselves as representatives of the Society on the Board of Directors of Connecticut Hospital Service for 1952.

CONNECTICUT MEDICAL SERVICE

Henry A. Archambault, Thomas J. Danaher, Joseph H. Howard, Louis F. Middlebrook, Walter I. Russell and Creighton Barker were named to represent the Society on the Board of Directors of Connecticut Medical Service. William H. Curley, Thomas M. Feeney, Denis S. O'Connor, Edward H. Truex, Jr., and Orpheus J. Bizzozero were appointed members of the Professional Policy Committee of Connecticut Medical Service.

STUDENT AMA AT YALE

A report was presented from Morris P. Pitock, chairman of the Committee on Student Members, concerning the organization of a chapter of the Student American Medical Association in the Yale School of Medicine. The establishment of this chapter has not yet been accomplished and the Committee was directed to arrange conferences and take any other necessary steps to increase the interest in a Yale chapter.

REPORTS

The Committee on Cooperation with the Yale School of Medicine and the Committee on Hospitals presented interim reports of their activities. The report from the latter committee included the statement that the committee had notified Connecticut Blue Cross that it wished to have professional medical service removed from the Blue Cross contract and transferred to the Connecticut Medical Service contract.

AMERICAN MEDICAL EDUCATION FOUNDATION

A progress report of the Connecticut Campaign for the American Medical Education Foundation was presented. It included a statement that to date $4,615 had been paid or pledged by 100 members of the Society. In addition 48 members reported that they have made contributions to their medical schools.

ARTHRITIS AND RHEUMATISM FOUNDATION

It was voted to approve the objectives of the Arthritis and Rheumatism Foundation and the edu-

cational material that the Foundation proposes to distribute.

GROUP HEALTH OF GREATER NEW HAVEN

Copies of the mimeographed promotional material for "Group Health of Greater New Haven" were distributed. This is a proposed cooperative medical service plan that is being sponsored by a number of members of the Society and others.

STUDENT MEMBERS

The following 14 medical students were elected to student membership in the Society.

John G. Bell, Jr., Bethel
Albany Medical College—Class of 1955
Pre-Med: Yale University
Parent: John G. Bell

Joseph J. Formica, Hartford
Tufts Medical School—Class of 1955
Pre-Med: Holy Cross
Parent: Nicola Formica

Richard M. Hays, Norwalk
Columbia University—Class of 1954
Pre-Med: Harvard College
Parent: Mortimer Hays

William Hillis, Greenwich
Cornell University Medical College—Class of 1955
Pre-Med: Wesleyan University
Parent: Dr. William A. Hillis

Walter L. Hogan, Jr., West Hartford
University of Vermont—Class of 1955
Pre-Med: Holy Cross College
Parent: Dr. Walter L. Hogan

Walter L. Johnson, New Haven
Yale Medical School—Class of 1955
Pre-Med: Yale
Parent: Arthur L. Johnson

William E. Lattanzi, New Haven
Yale Medical School—Class of 1955
Pre-Med: Yale
Parent: Frank A. Lattanzi

Peyton H. Mead, West Hartford
Columbia University—Class of 1954
Pre-Med: Williams College
Parent: George J. Mead (deceased)

Robert L. Nolan, New Haven
Yale Medical School—Class of 1953
Pre-Med: N. Y. University
Parent: John L. Nolan

Juanita B. Rentsch, Derby
Medical College of Virginia—Class of 1955
Pre-Med: University of Michigan
Parent: Dr. James G. Brown

Clinton B. Seeley, Stamford
University of Rochester—Class of 1955
Pre-Med: Massachusetts Institute of Technology
Parent: Nathaniel S. Seeley

William A. Stevens, Danbury
New York Medical College—Class of 1955
Pre-Med: Providence College
Parent: Thomas E. Stevens

Marshall A. Taylor, North Haven
New York Medical College—Class of 1955
Pre-Med: Harvard College
Parent: Dr. Sterling P. Taylor

Hilbert Ziskin, New Haven
Boston University—Class of 1955
Pre-Med: Yale University
Parent: Benjamin Ziskin

Past President's Pictures

The collection of pictures of past presidents of the Society is growing rapidly, but there are still some more to be obtained. The secretary's office is seeking further assistance in completing the series. Listed below are the names of past presidents whose pictures are still missing. Can you help?

1792 Leverett Hubbard, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1822 Thomas Hubbard, New Haven
1829 John S. Peters, Hebron
1832 William Buel, Litchfield
1834 Thomas Minor, Middletown
1837 Silas Fuller, Hartford
1841 Elijah Middlebrook, Trumbull
1843 Luther Ticknor, Salisbury
1851 Rufus Blakeman, Greenfield
1853 Richard Warner, Cromwell
1854 William H. Cogswell, Plainfield
1856 Benjamin H. Catlin, Meriden
1858 Ashbel Woodward, Franklin
1861 Josiah G. Beckwith, Litchfield
1865 Nathan B. Ives, New Haven
1866 Isaac G. Porter, New London
1867 Charles Woodward, Middletown
1870 Charles F. Sumner, Bolton
1873 Ira Hutchinson, Cromwell

1874 Lowell Holbrook, Thompson
1875 Pliny A. Jewett, New Haven
1878 Charles M. Carleton, Norwich
1879 Alfred R. Goodrich, Vernon
1880 Gideon L. Platt, Waterbury
1882 William G. Brownson, New Canaan
1883 Elisha B. Nye, Middletown
1884 Benjamin N. Comings, New Britain
1885 Elijah C. Kinney, Norwich
1887 Francis Bacon, New Haven
1888 George L. Porter, Bridgeport
1889 Orlando Brown, Washington
1893 Francis D. Edgerton, Middletown
1895 Seth Hill, Stepney
1899 Charles S. Rodman, Waterbury
1901 John H. Grannis, Old Saybrook
1905 Edward H. Welch, West Winsted
1905 Nathaniel E. Wordin, Bridgeport
1930 Frederick G. Graves, Bethlehem

Meetings Held in February

February 6—Committee on Hospitals
February 7—Nominating Committee
February 13—Committee on Emergency Medical Service
February 14—Program Committee, Annual Meeting
February 18—Committee on Cooperation with the Yale School of Medicine
February 20—Cancer Executive Committee
February 21—Council

THE DOCTOR'S OFFICE

Theodore Goldstein, M.D. announces the opening of his office for the practice of child psychiatry at 576 Farmington Avenue, Hartford.

Charles Phillip LeRoyer, Jr., M.D. formerly at Connecticut Veterans Hospital, Rocky Hill, wishes to announce his association with George K. Fenn, M.D., F.A.C.P., in the practice of internal medicine at 8 Endicott Street, Beverly, Massachusetts.

A New Development in Malpractice Insurance

Of growing concern to physicians everywhere is the tendency on the part of courts to award higher and higher amounts in malpractice suits. In many cases such judgments reach proportions sufficient to place the doctor's finances in jeopardy for many years to come, perhaps seriously impairing his estate.

For example, a very recent case in another State has come to our attention which involves a $70,000 verdict. The unfortunate doctor in this case was alleged to have set the amperage too high on an x-ray machine used in treating a patient. A Superior Court jury awarded the injured patient $50,000 in damages and an additional $20,000 to her husband for medical expenses and loss of his wife's services.

Here in Connecticut the $20,000 statutory death limit recently was abolished. As a result, it has focused the attention of physicians upon the advisability of carrying more adequate protection in these times.

Because of the upward trend in damage claims, it behooves each physician to check into his Professional Liability protection. Under our Connecticut State Medical Society Group Professional Liability Plan in the Ætna Casualty & Surety Company of Hartford, Connecticut, members can obtain protection at a very fair premium, as indicated below:

5,000/15,000	$19.00	50,000/100,000	$33.82
10,000/30,000	24.70	50,000/150,000	34.96
15,000/45,000	26.98	75,000/150,000	36.48
25,000/75,000	30.02	100,000/300,000	38.95

To carry only minimum limits of protection, 5,000/15,000 for instance, in these times is false economy. As will be observed by the above schedule, ten times this amount of protection is available for less than twice the $19 minimum limits premium.

Unquestionably this is a subject which deserves the attention and serious consideration of every physician. With the trend toward higher verdicts because of today's devalued dollar, no physician can afford to be caught with too little, too late!

Bone Saw and Drill Table

CHARLES WEER GOFF, M.D., *Hartford*

Wood is similar to bone as a working material. Most bone instruments are adapted from wood working tools. A table saw is an old wood working instrument and is also a natural device for cutting and shaping bone. Such a table was designed and has been used by the author for the past fourteen years as an orthopedic accessory.

There must be many saw tables in use. Recently Rabson reported the use of a somewhat similar table. He shows the operator holding bone about to be cut with a uterine tenaculum. This is a dangerous way, is not secure, and frequently the bone piece will "flip" out of control. This cannot happen with the present author's apparatus. In cutting principles, both table saws are similar.

The illustrations with legends describe the saw and drill apparatus.

Material: strap iron and rods, bent to shape and electrowelded.

Size: overall 10 x 12 x 18 inches. Platform 10 x 12 inches.

Finish: cadmium plated (inexpensive).

Saw and drill: originally an Albee, later adapted to the Luck saw.

Uses: shaping bone implantations; cutting bank bone to size, as slivers, strips, brickettes, pegs or "close pin grafts." Preparing bank bone for preservation by cleaning it of soft parts and articular cartilage. Drilling dual on-lay grafts at same level for accurate placement of screws. Motor can be instantly removed from table and used in operative area. Os purum is readily shaped and drilled.

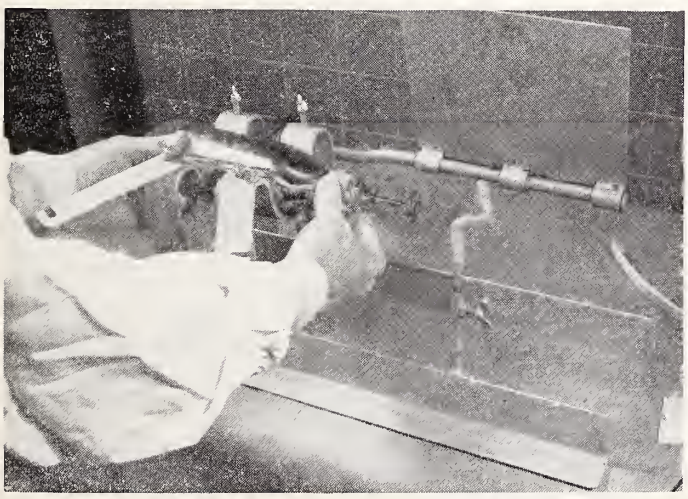


FIGURE 1

Saw table, sterilized as a unit, placed on side table in operating room. Slotted strap iron holding pieces are open, saw being placed on bed, slotted saw platform tilted up. Adjustable support with thumb screw is indicated by arrow.

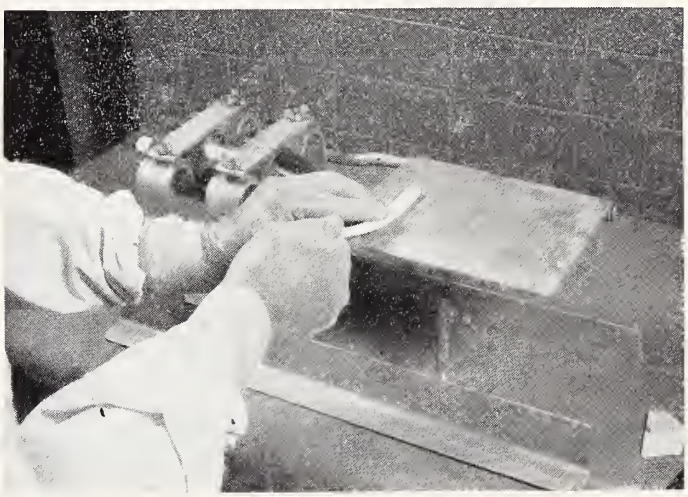


FIGURE 2

Method of cutting longitudinally. Saw revolves toward operator and is quite safe. Speed of motor regulated by foot switch.

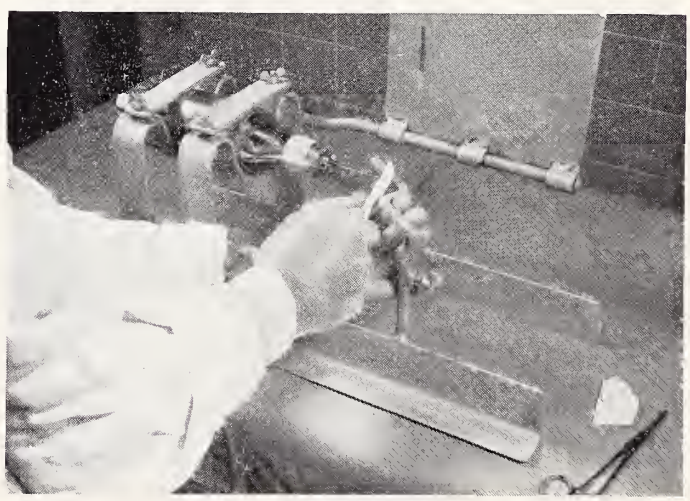


FIGURE 3

Method of drilling. A burr can be used in place of drill, for finer shaping or removal of soft parts from bank bone before refrigeration.

REFERENCE

Rabson, Moses: A Table Attachment for the Electric Saw. J. Bone and Joint Surg., 32-A, 4, pp. 948-49, 1950.

COMMUNITY SERVICE

A rising number of medical associations are demonstrating how they can meet the needs of the people right in their own communities.

Twenty-four hour emergency medical call systems are an example of the community services embraced in these programs.

More than 350 of these plans are in operation. Twelve plans are now being sponsored or are under study by county and local medical associations in Connecticut.

Community Action Wins Community Support

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
John E. Flaherty, Rockville
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Three New Emergency Call Systems Started

New emergency medical services in Hartford, New Britain and Manchester were announced early in February by the Hartford County Medical Association.

The emergency services are available to residents through day-and-night telephone answering systems in each community.

The systems went into operation February 10, the effective date for the new telephone directories in the area. Single trunk line numbers in each of the three cities are listed in both the white and yellow pages of the directories. By dialing the number for their community, residents may obtain emergency medical attention when they do not have a family physician or when he cannot be reached. Medical services are furnished by physicians registered on rotating emergency panels filed with the telephone answering services.

The new programs are being conducted in cooperation with local medical associations. Costs, including installation of trunk lines, monthly rental charges, advertising and telephone exchange expenses are underwritten by the Hartford County Medical Association.

Operating procedures are supervised by the local medical groups in New Britain and Manchester, while the Hartford system will be administered by the County Medical Association. Emergency services in the three communities previously were available under plans sponsored by the local medical associations, but not on the large scale embraced in the new program.

The projects were started following a lengthy survey of emergency needs and facilities throughout the county. The survey was conducted by the Public Relations Committee of the Hartford County Medical Association, under the chairmanship of Dr. Burdette J. Buck, Hartford.

AMEF Committee Reports Campaign Progress

The Connecticut Committee for the American Medical Education Foundation reported February 7 that contributions and pledges had reached a total of $5,416.

As of that date, 125 physicians had contributed or pledged to contribute to the fund to aid the 79 approved medical schools in the United States.

In addition to these returns, 49 physicians indicated they are already contributing directly to their medical schools.

The report covers a 60 day period since the initial campaign mailing early in December, 1951. The total number of responses, including physicians who indicate direct contributions to medical schools, was reported as follows: Hartford County—54; New Haven County—39; Fairfield County—33; Litchfield County—13; New London County—13; Middlesex County—11; Windham County—8; and Tolland County—3.

Norwalk Medical Society Starts Emergency System

A 24-hour emergency medical call system will be inaugurated in the Norwalk area sometime this month under sponsorship of the Norwalk Medical Society.

In announcing the new system, Dr. Edward A. Rem, recently elected president of the Society, said its operation will be supervised by a special committee. The calls will be routed through a commercial answering service and medical attention will be provided by physicians registered on a rotating emergency panel. The plan was approved at a recent meeting of the Society, following study of local needs and facilities by a committee appointed several months ago.

NEWS FROM WASHINGTON

New House and Senate Bills

HR5871—EMIC. By Mrs. Bosone, of Utah, January 8. To provide for the national defense by enabling the States to make provision for maternity and infant care for wives and infants, and hospital care for dependents, of enlisted members of the Armed Forces during the present emergency, and for other purposes. Referred to the Committee on Armed Services.

Comment: This bill is identical with S2337 (Lehman) introduced October 20, 1951. These bills would establish a federal-state (fifty-fifty matching basis) program for paying the cost of maternity and infant care for dependents of military service personnel up to the grade of warrant officer. Established also on the same financial basis would be a program to cover the expenses of any hospital service for dependents. In both programs the States would be permitted, "consistent with economy and efficiency . . . to . . . utilize the services of voluntary nonprofit agencies or organizations in the health or medical field . . ."

HR5892—Veterans—Presumption of Service Connection. By Mr. Rankin, of Mississippi, January 8. A bill to liberalize the basis for establishing wartime service connection for active tuberculosis, the psychoses, and multiple sclerosis. Referred to the Committe on Veterans' Affairs.

Comment: At the present time multiple sclerosis appearing within one year, psychoses appearing within two years, or tuberculosis appearing within three years from the date of discharge developing a 10 per cent or more disability, establish a basis for presumption of service connection. This bill would create a presumption of service connection if any of the three developed within three years.

HR5903—Universal Military Training. By Mr. Van Zandt, of Pennsylvania, January 8. To provide for the administration and discipline of the National Security Training Corps, and for other purposes. Referred to the Committee on Armed Services.

Comment: This bill proposes machinery for the administration and discipline of the National Security Training Corps provided for in Public Law 51 of the first session of this Congress. Provisions are virtually identical with those of HR5904 below.

HR5904—Universal Military Training. By Mr. Vinson, of Georgia, January 8. To provide for the administration and discipline of the National Security Training Corps, and for other purposes. Referred to the Committee on Armed Services.

Comment: This bill, introduced by the chairman of the House Armed Services Committee, will form the basis for a committee bill following public hearings which have been scheduled. Witnesses representing the AMA have requested time to testify. The hearings are expected to continue for several weeks. The bill provides machinery for the administration and discipline of the National Security Training Corps. Matters of most concern to the medical profession are that: (1) Trainees during their six months training period in the corps will be furnished, among other things, with hospitalization, medical, surgical, and dental care. (2) Trainees who become disabled or die in the line of duty would not receive benefits from the Veterans Administration as do members of the military services; instead, following release from the corps cash benefits would be paid them or their beneficiaries under the Federal Employees Compensation Act, which is administered by the Department of Labor. The training agency would not be responsible for making any determinations except as to whether the injury or death was training connected. (3) The six months training period could be extended by the training agency with the consent of the trainee, or his next of kin if he is "incompetent," for the purpose of furnishing hospital, medical, surgical, or dental care, but the trainee would be transferred to the jurisdiction of the Department of Labor for benefit determination at the earliest time consistent with the health and well being of the trainee.

HR6078—Public Assistance Benefits Under Private Medical Care. By Mr. Gerald R. Ford, Jr., of Michigan, January 17.

This bill proposes to extend public assistance benefits—under Social Security Act—to persons under care in private institutions whom the law now excludes from eligibility. These benefits could be in form of cash payments or reimbursement for institutional care, under provisions of HR6078. Prospective recipients fall in three categories: Indigent individuals 65 and older; the blind, and persons 18 or

older who are permanently and totally disabled. Rep. Ford's proposed amendment is applicable to persons in any of these groups who are patients in private institutions for treatment of tuberculosis or mental disease. Financial assistance would continue to be withheld for cases under care in public hospitals and sanatoria.

HR6213—Social Security Amendment. By Mr. Burnside, West Virginia, January 24. To amend the Social Security Act to provide disability insurance benefits for totally disabled individuals. Referred to the Committee on Ways and Means.

Comment: Would amend the Social Security Act to provide insurance benefits for totally disabled individuals. Provides that the Administrator of the FSA shall make regulations for determinations of disability and redeterminations. It would be permissive for a physician, not an employee of the United States, to be desginated to make examinations and be paid therefor. Beneficiaries who refuse to be examined without good cause and refuse to accept rehabilitation services could be denied benefits. The administrator would be authorized to enter into voluntary working arrangements with private physicians, dentists, hospitals and other individuals, groups and agencies providing medical care and hospitalization for examination and rehabilitation of beneficiaries. A totally disabled individual is defined as one unable to engage in any substantially gainful activity by reason of any medically demonstrable physical or mental impairment, including blindness. This bill is similar to the proposal contained in HR6000 of the 81st Congress, opposed by the AMA, and dropped from the bill which became law.

S2552—Female Military Medics. By Dr. Hunt, of Wyoming, January 30. To authorize the appointment of qualified women as physicians and specialists in the medical services of the Army, Navy and Air Force. Referred to the Committee on Armed Services.

Comment: Would authorize the commissioning of females as officers to perform medical, dental, or medical service duties in the armed forces. This bill is similar to HR4384 of the last Congress which passed both the House and Senate. Since the Senate slightly amended the House-passed version last Congress it was necessary that conferees be appointed to agree on a compromise. The bill was sent to conferees in the closing days of the session and died when Congress adjourned. Last Congress the Army and Air Force favored the bill but the Navy had objections. Senator Hunt's office advises that the Navy has now withdrawn its objections and the bill will be supported by all branches of the military service.

HR6288—Female Military Medics. By Mr. Durham, of North Carolina, January 29. To authorize the appointment of qualified women as physicians and specialists in the medical services of the Army, Navy and Air Force. Referred to the Committee on Armed Services.

Comment: This bill is identical with S2552.

VA Report Emphasizes Staffing Problems

Veterans Administration's annual report to Congress, covering fiscal 1951 (through June of 1951), emphasizes staffing problems which are not as acute now as during the period covered. During fiscal 1951 some 500 VA physicians went on active military duty, but subsequently enough additional doctors were recruited by VA to show a net increase in the total by last December. During fiscal 1951, VA encountered trouble in staffing 15 new hospitals, as well as a number of hospitals in rural areas, where physicians are reluctant to serve. The 17 new hospitals scheduled for opening this year, on the other hand, will be located in metropolitan areas.

VA lists approximately two-thirds of its cases as nonservice connected and one-third as service connected, or about the present ratio. The period covered is July, 1950 through June, 1951. Data in the tabulation below are from the Veterans Administration report.

ILLNESS	SERVICE CONNECTED	NON SERVICE CONNECTED	AVERAGE STAY CALENDAR 1950	COST PER PATIENT PER DAY 1951	INCREASE OVER 1950
	PER CENT	PER CENT	DAYS		PER CENT
All patients	35.0	65.0	60.8	$11.66	7.0
TB	41.5	58.5	205.8	13.82	1.5
Psychosis	51.0	49.0	482.1	7.22	4.5
Other NP	24.5	75.5	60.3	7.22	4.5
General M&S	12.2	87.8	30.8	16.47	9.2

Radioisotopes (notably Iodine 131) are being used successfully in treatment of patients with hyperthyroidism. Encouraging results also have been obtained in polycythemia vera and, diagnostically, the scintillation counter is being used to good advantage, particularly at VA Center in Los Angeles, according to the report. VA now has 15 radioisotope



Americaine

TOPICAL ANESTHETIC OINTMENT

WITH 20% DISSOLVED BENZOCAINE FOR RAPID, EFFECTIVE, PROLONGED PAIN RELIEF

Most Potent — Least Toxic — Antiseptic — Facilitates Healing — INDICATIONS: Eczemas, Hemorrhoids, Burns, Insect Bites, Sunburn, Pruritus Ani et Vulvae, Post-Operatively, Post-Episiotomies, Tender Nipples, Abrasions, Poison Ivy, etc.

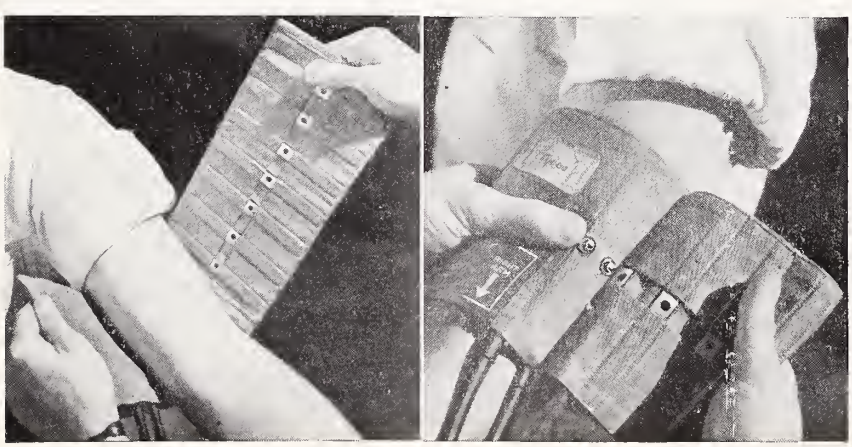
Available "Clear" and "With Chlorophyll"

all over Connecticut
more and more doctors now call

American



ON 5 TIMES FASTER AND OFF 10 TIMES FASTER



In taking accurate blood pressure readings, the TYCOS Hook Cuff goes on five times faster and comes off 10 times faster than old fashioned bandage type cuffs. Just circle the arm once—and hook it together. More accurate too—because stainless steel ribs insure uniform pressure over entire width of cuff. Snugly fits every adult arm, fat or lean. The accurate TYCOS Hook Cuff comes as standard equipment with both the Tycos Mercurial and Tycos Aneroid.

TYCOS HOOK-TYPE CUFF NO. 5080

rgical

Yes, busy doctors are making it a constant practice to call American Surgical FIRST whenever they have a mechanical problem to solve. If you, also, want quality equipment, and courteous and appreciated service by men who know your individual problems, today call Bridgeport 5-3116 or Enterprise 3190.

BIRTCHER

DTOME ELECTROSURGICAL UNIT

BLENDTOME contains all facilities of a major unit, amply powered to perform effectively all the require- of minor surgery.

e generated current for swift, sure setting.

rk-gap current for hemostasis and coagulation.

h tube and spark-gap currents used together or separ- y.

e Oudin mono-polar currents for all fulguration and ccation technics.

DTOME ELECTROSURGICAL UNIT–MODEL 750

THE *American Surgical*
SUPPLY AND EQUIPMENT COMPANY
1715 BARNUM AVENUE : P. O. BOX 150 : BRIDGEPORT, CONN.

MAIL TODAY FOR QUICK SERVICE

The American Surgical Supply and Equipment Co. Bridgeport, Conn.
Gentlemen: Kindly have your representative call on
Date..... Time.....
I am interested in: Ointment ☐ Blendtome ☐ Hook Cuff ☐
Dr. ..... Address.....

units in operation and thus stands No. 1 among governmental agencies pioneering in medical application of atomic energy. About ten more are scheduled to be opened before end of 1952. The Los Angeles center was the scene recently of a symposium on results achieved to date by these radioisotope units, which hold promise of becoming known as VA's most significant contribution to medical progress.

U. S. Budget Boosts Civil Defense, National Science Foundation Funds

President Truman's budget message, given to Congress January 21 with his budget, again urges passage of legislation for federal aid to medical education and to local public health departments. The President also asked for extension of Social Security benefits to the armed forces, to public employes and to farmers and irregularly-waged farm and household help. While making no mention of National Compulsory Health Insurance, Mr. Truman did cite his new Comission on the Health Needs of the Nation, to which he has referred health problems.

Tabulated below are the more important health and welfare programs as given in President Truman's budget for fiscal 1953, covering the period July 1952 through June 1953. The first column lists money actually appropriated by Congress for use of the agencies from last July through next June. The second column is the Budget Bureau's estimate of justified expenditures for this period. The third column lists the sums President Truman has asked Congress to appropriate to the various agencies to support their operations from next July through June of 1953.

Budget figures in third column represent the maximum the Budget Bureau has permitted the various agencies to ask of Congress, and generally represent less than the agencies' own original requests. Items in third column are subject to increase or decrease by Congress.

Task Force on Handicapped Completes Study

A Task Force on the Handicapped, operating under Office of Defense Mobilization, has completed its report on problems involved in making better use of the handicapped. It recommends more intensive efforts on State and local levels, where it reported that existing resources were not being fully utilized. On the federal level, the Task Force proposes that a national plan be developed "for the recruitment of additional students in the medical and allied fields most urgently needed in rehabilitation

AGENCY	CONGRESSIONAL APPROPRIATION FOR FISCAL 1952	BUDGET BUREAU'S ESTIMATE, FISCAL 1952 SPENDING	PRESIDENT'S BUDGET REQUEST FOR FISCAL 1953
All U. S. Health, Welfare	$2,562,000,000	no figure	$2,578,000,000
Total FSA*	1,737,478,308	$1,791,846,373	1,752,443,884
Chlidren's Bureau, grants	31,500,000	32,442,786	30,000,000
Total Public Health Service (all programs, including aid to States)	350,537,052	334,490,337	302,398,000
Hill-Burton Hospital program†	182,500,000	155,109,828	154,700,000
Cancer Institute	19,676,000	20,648,066	15,371,066
Mental Health Institute	10,566,987	11,005,438	10,895,000
Heart Institute	10,097,000	13,105,274	9,749,000
Dental Research Institute	1,645,654	1,739,766	1,936,000
Other Institute expenses	15,806,000	15,781,165	16,876,000
AEC, biology and medicine	23,285,500	no figure	24,600,000
VA, medical care‡	903,352,012	907,775,770	895,000,000
Civil defense, medical	1,681,562	no figure	2,600,000
All—U. S. medical stockpiling	50,000,000	no figure	193,000,000
National Science Foundation	3,500,000	no figure	15,000,000
Indian Affairs, medical	16,528,015	no figure	22,346,000

*Excluding a request for $511 million to be submitted to Congress later.

†Part of these totals are for liquidation of prior obligations; new money totals $82.5 million for fiscal 1952 and $75 million for fiscal 1953.

‡Including a proposed supplemental appropriation of $30 million but excluding funds for hospital construction.

and that such a plan be capable of implementation by the professional associations, private and government agencies and others concerned." Also suggested is a program of graduate student grants for physicians and others needed in rehabilitation, to be administered by U. S. Public Health Service. Dr. Theodore G. Klumpp, president of Winthrop-Stearns, Inc., is chairman of the 11 member Task Force, which includes three other physicians.

Dr. Cushing Resigns as VA Medical Director

The recent resignation of Dr. Edward H. Cushing furnished more ammunition for some of the veterans' organizations seeking VA Administrator Carl Gray's scalp. However, discriminating observers noted: (1) in contrast with Dr. Paul B. Magnuson, when he broke with Gray in January, 1951, Dr. Cushing declined to state publicly why he was stepping out; (2) there was no question of lay interference with VA medical policies, the differences being between Chief Medical Director Joel T. Boone and his assistant in charge of research and education, Dr. Cushing, and (3) selection of Dr. George M. Lyon as replacement was a happy choice that should be well received by the scores of medical educators with whom he will deal.

George Marshall Lyon, a West Virginia pediatrician before World War II, is a modest, white haired individual of 56 years whose interests during the past decade have been in the field of atomic medicine. He joined VA in 1947, following separation from active duty in the Navy, and soon afterward founded the radioisotope research program that ranks today as VA's proudest achievement. He is a graduate of Johns Hopkins Medical School and is a consultant to AMA's Council on National Emergency Medical Service. Drs. Boone and Lyon went to Chicago to give assurance to assembled medical deans and AMA officials that VA's research and education activities are going well and merit their continued support.

FDA Issues Regulations on Prescription Drugs

February 5 issue of *Federal Register* carried proposed regulations under recent Durham-Humphrey amendment to Federal Food, Drug and Cosmetic Act. Individuals or organizations wishing to comment on them have 30 days from that date to file written statements or request oral hearings. Following are some of the new rules: in case of a drug sold directly to a physician, no directions-for-use are required on label if it states essential information as to composition and it is a drug with which practitioners are familiar; when a doctor gives a prescription orally, as over telephone, it is pharmacist's responsibility to reduce it to writing "contemporaneously with or prior to the dispensing of the drug;" all injectable drugs, with exception of insulin, are placed in "by prescription only" class.

Fairfield County Leads Leaflet Distribution

Approximately 4,000 copies of the Society's leaflet, "Serving Physicians–Serving the People," have been distributed through physicians' offices in Fairfield County.

This lead is closely followed by Hartford County, where more than 3,500 leaflets have been ordered. Physicians in New Haven County have requested 3,200 leaflets and distribution in other counties has reached the following totals: Litchfield County—600; Middlesex County—400; New London County—200; Tolland County—200.

The leaflet contains a positive story of the accomplishments and activities of medical associations. It is available for physicians' offices without charge through the Society's Public Relations Section.

Cancer Day — March 19

The Connecticut Cancer Conference sponsored by the Association of Connecticut Tumor Clinics, the Connecticut Cancer Society and the Connecticut State Medical Society will take place on the afternoon of March 19 at the Hotel Taft in New Haven. As usual, the list of speakers is an impressive one. The subjects chosen for discussion are such that all physicians, whether working in special fields, or not, will be interested. Judging from past interest and attendance, it will be a highly successful meeting.

Avocationers, Incorporated

A nonprofit organization incorporated under the laws of Connecticut and known as Avocationers has been formed to provide avocational projects for those who may need guidance in occupational therapy and creative handiwork. It is planned particularly for older people and those about to retire from active business. A medical staff is planned. The shop will be located at 134 Collins Street, Hartford.

MILITARY AFFAIRS

COMMITTES ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Members Who Have Entered Military Service

Capt. William M. Stahl, Jr. (formerly of Danbury)
APO 187 c/o Postmaster
San Francisco, California

Defense Department, UMT Commission Support AMA on Medical Student Deferment

Defense Department and National Security Training Commission are in agreement with American Medical Association that premedical and medical students, after six months of Universal Military Training, should be deferred from service in the reserves until completion of their schooling and internships. The two agencies presented their views before the House Armed Services Committee, which is holding hearings on bills to implement UMT. If Congress puts UMT into effect, it will be run by Defense Department but supervised by the Civilian Commission.

For the first year at least, deferments would not be an important factor as Defense Department contemplates starting out with only 60,000 18 year old volunteers. Eventually as many as 800,000 inductees could be trained annually.

Prior to opening of the hearings, AMA urged the Commission to support deferment of reserve service through internships and in some cases residencies. Thus men would serve their full seven and one half years in the reserves as physicians, not as students. In subsequent testimony before the Committee, Karl T. Compton (PH.D.), a Commission member, agreed with the AMA, saying ". . . recall to reserve duty could well be held in abeyance until schooling was completed." A Commission spokesman explained that this meant deferment through internship but not necessarily residency.

Assistant Secretary Anna Rosenberg testified that Defense Department was opposed to blanket deferment of college students from reserve service after completion of basic training. She said later, however, that the Department believed medical students should be allowed to finish their education without interruption, once they have completed the six months of training.

Before the House Committee is HR5904, introduced by Chairman Vinson (D-Georgia). Chairman Russell (D-Georgia) of the Senate Armed Services Committee is sponsor of the bill before his Committee. It is similar to the House bill but would give the Commission more budgetary control, define reserve service in more detail and limit reserve service to three years rather than seven and one half.

Dr. Roscoe L. Sensenich, former AMA president, presented supplementary views of the Association to the Commission, just before start of the House Hearings. In addition to the deferment suggestions, he made the following recommendations:

1. Introduction and preinduction physical examinations of trainees and periodic examinations of reserve should be conducted by civilian physicians on a fee basis or by reserve personnel.

2. The AMA favors establishment of a national civilian board to select the medical and allied personnel necessary to man a UMT program and to determine the extent of the need.

Military Supplied 1,225,000 Pints of Blood by Red Cross in 18 Months

American National Red Cross, in a fourth anniversary review of its blood program, announces it has collected and turned over to the military forces 1,225,000 pints of blood since the start of the Korean War. Approximately 160,000 pints were shipped to the Far East as whole blood, the rest processed into plasma. During the same period, Red Cross collected and processed 1,861,000 pints for civilian use. Dr. George F. Lull, AMA secretary and general manager, renewed the pledge of America's physicians to "do everything possible to make the blood

program a continuing success." E. Roland Harriman, Red Cross president, commented on the cooperation received from AMA, American Hospital Association, American Public Health Association and the American Association of Blood Banks. He said: "At every stage . . . we have had the unremitting aid and guidance of the American Medical Association and individual physicians."

Red Cross and the cooperating blood banks will be the collecting agency in a National Blood Program now being set up under direction of a committee headed by Dr. G. D. Cummings. The group, which will report to the Health Resources Advisory Committee in the Office of Defense Mobilization, will coordinate all collecting, processing, distributing and research efforts.

Red Cross has set a goal of 300,000 pints per month for military use and 125,000 for civilian, for a total of 425,000. December collections reached 353,000.

AMA Trustee Appears Before House Committee on Medical Phase of UMT

Dr. F. J. L. Blasingame, AMA trustee, appeared before House Armed Services Committee on medical aspects of Universal Military Training. Among the points made in his prepared testimony were (a) need for deferment of medical students from serving in the reserve until completion of schooling, (b) use of civilian physicians on fee basis or reserve personnel in making physical examinations at all stages of training, and (c) creation of a national civilian board to determine medical and allied personnel needed for UMT. House Committee concluded hearings in January.

The House Armed Services Committee since hearings were concluded on January 31, has been meeting in closed session for the purpose of drafting a bill. On February 6 the Committee reported out a bill by vote 27-7 (unofficial). A copy of the final draft is not yet available but we are advised that the Committee rejected the recommendation of the AMA that premedical and medical students be deferred from reserve obligation until completion of their education (education includes internship and residency). There are no specific provisions in the final draft of the bill which provide such deferment for either the six months training period or for the 7½ year reserve obligation period. It is reported that several Committee members believe deferments should be included in the Reserve Reorganization bill which is pending before Congress.

Medical Care of Veterans

The provisions and purposes of the Tennessee resolution "Concerning Medical Care of Veterans" introduced into the AMA House of Delegates at the session in Los Angeles in December 1951 were incorrectly quoted. Dependents of veterans were not mentioned in the Tennessee resolution and under its provisions chronic cases would be admitted to VA hospitals. Following is the text of this resolution.

A RESOLUTION CONCERNING THE MEDICAL CARE OF VETERANS

Be it resolved by the House of Delegates of the American Medical Association that we recommend to the Congress of the United States, the adoption of a program of medical and hospital benefits for veterans as follows:

Part 1. That the veterans who require hospitalization for the following types of disabilities be eligible to services in veterans' hospitals:

A. Service connected disabilities.

B. Tuberculosis.

C. Mental illness.

D. Other forms of chronic illness which require hospitalization for more than ninety days.

E. Disabilities in dispute as to whether service connected or not.

Part 2.

A. That a standard medical and hospital insurance policy be made available, at government expense, to every veteran who is unable to pay the premium cost of such coverage.

B. That the insurance coverage embrace all disabilities which are not eligible for admission to a veterans' hospital, as outlined in Part 1, excepting disabilities which are covered by compensation laws or other forms of public liability.

C. That "the ability to pay" for such insurance coverage be determined on the basis of "the taxable income" of the veteran as determined for federal income tax purposes.

D. That the Congress of the United States determine the income level at which veterans would cease to be eligible for this benefit.

E. That the insurance policy be renewable each year on the same basis as the original.

F. That the government, through existing agencies, issue checks to eligible veterans which are payable only for such insurance coverage, and cashable only when signed by the veteran and countersigned by an approved insurance company.

FROM OUR EXCHANGES

The Stevens-Johnson Syndrome appears as a name more and more frequently in medical literature. Briefly the syndrome as a clinical entity has an acute onset of fever and prostration associated with a cutaneous eruption, severe membraneous stomatitis, and a purulent conjunctivitis. The oral lining is usually edematous and covered with numerous vesicles which soon rupture, to be followed by the formation of a thick membranous exudate which soon sloughs off. There is an attempt made to differentiate this syndrome from erythema multiforme exudaturum, which is not entirely successful.

Pritchett and Austin describe such a syndrome occurring in identical twins *(Jour. Med. Assoc. of Georgia*, 40.9). Penicillin and streptomycin cleared the complicating pneumonitis without altering the florid development of the syndrome. Oral administration of terramycin and aureomycin appeared definitely to decrease the length and severity of the illness. From the literature we gain a vague impression that terramycin and aureomycin are the antibiotics of choice in this syndrome.

* * * *

Chenoweth *(Ohio State Med. Jour.*, 47.10) considers the matter of "Medical Supervision of Boxing." He stresses as important that a careful history be taken and that a thorough general physical examination be made. In addition he thinks that every boxing candidate should have a roentgenogram of the chest taken at six feet and also one of the skull. If any significant abnormalities are found the physician should urge the young man to give up boxing. If the physician is in a position of authority he should not hesitate to reject candidates who are not physically fit for boxing. By so doing he may save some young man's life. In addition to medical supervision of boxing it is important to supervise the physical training. The training should be under the direction of an experienced trainer or coach. If the contestant cannot be taught a reasonable amount of skill and develop the needed amount of endurance he should be advised to quit boxing.

* * * *

In "The Value of Histamine Skin Tests in Meniere's Disease" *(Brit. Med. Jour.* 4739) Haggie of London Hospital reports on intradermal skin tests on 50 cases of this disease in an average age group of 47 years. There were 35 men and 15 women in the group. A control group of 50 was used comprising 33 men and 17 women. Contrary to previous statements regarding the association of Meniere's disease with allergy, only two suffered from migraine and one had true asthmatic attacks. None gave a history of urticaria, angioneurotic edema, hay fever or any food sensitivity in relation to vertigo. The deciding factor in selecting the control group was the absence of any allergic disease or migraine. Final results showed little significant difference between those with Meniere's disease and the controls, using the Atkinson method (or modifications) of histamine skin tests. To date the pattern and pathology of the disease is the same as first described and demonstrated by Meniere, but the etiology remains undetermined. Many theories exist and each supports a corresponding method of treatment which produces much the same degree of success.

* * * *

Luongo, Reid and Weiss report a study of the effect of ACTH in three cases of trichinosis *(N. E. Jour. Med.* 245.20) together with an experimental study of its effect in animals. New England is one of the areas where trichinosis continues to be the commonest parasitic disease of serious consequence. All three cases responded favorably to ACTH.

* * * *

"Surgical Treatment of Esophageal Lesions" by Paulson in *Arizona Medicine* 8.11 emphasizes the rapid advances in the field of esophageal surgery during the last decade. Satisfactory one stage procedures can now be performed on a variety of esophageal lesions: congenital atresia with tracheoesophageal fistula; acquired tracheoesophageal fistula: acquired stricture; perforation or rupture of the esophagus; diverticula; cardiospasm; benign and malignant tumors.

* * * *

Deafness is a ubiquitous condition which affects one person in twenty in the United States, according to Wright and Guilford in "Therapy of Deafness" *(Texas State Jour. Med.*, 47.9). The management of

the deaf patient belongs in the hands of the medical profession as it requires a complete and correct diagnosis. Of equal importance is a complete knowledge of available therapeutic measures against deafness. The following classification is suggested for therapeutic purposes: (1) Deafness amenable to therapy—(a) Conduction deafness from all causes; (b) Reversible nerve deafness. (2) Deafness not reversible and which must be treated by other methods. The armamentarium in the management of this nonreversible type of deafness has five major considerations: conservation of residual hearing, selection of hearing aid, auditory training, lip reading, and speech training.

Physicians need to accept the responsibility for the diagnosis and treatment of deafness which can be eured and to direct the management of deafness which is not reversible. Complete hearing evaluation and therapy should be made available to all deaf patients. The establishment of hearing clinics and hearing centers should be encouraged, thus to save best the patients in need of acoustic prosthesis. Evaluation of hearing aids should be made at the professional level. Auditory and speech training should be made available for every deaf child.

* * * *

"ACTH and Cortisone Therapy of Ocular Conditions" by Polan in *W. Va. Med. Jour.*, 47.9 emphasizes the rapidity with which this subject is expanding. Greater experience must be attained and a vast amount of data compiled and evaluated before we ean hope to arrive at the true value of cortisone and ACTH in ophthalmology. We are a long way from the final answers but these products give great promise of becoming real factors in the future treatment of ocular lesions.

STATE OF CONNECTICUT

State Veterans Hospital and Hospital for Chronic Illness, Rocky Hill

Outline of Staff Organization

Recommended by Medical Advisory Committee December 21, 1948. Amended April 19, 1949. Amended June 23, 1949. Amended November 29, 1951.

I. General:

A. The medical and surgical staff of the hospital facility at Rocky Hill for Veterans and for the Chronically Ill is appointed by the chairman of the Joint Commission, i.e., the Commission for the Chronically Ill, Aged and Infirm and the Veterans Home and Hospital Commission. The staff appointments are for a period of one year, being made annually on or before July 1.

B. New staff members are appointed to the staff on the nomination of the Medical Advisory Committee and approved by the Joint Commission. The Medical Advisory Committee passes on their qualifications. Appointments are made to the Consulting Staff, Attending Staff or Associate Attending Staff. Candidates for Attending or Consulting Staff appointments must be certified by their respective Specialty Board. Younger men who have all the necessary hospital training and are in the process of Board Certification may be appointed to Staff positions or where their services are specifically needed.

II. Organization of the Medical and Surgical Staff:

A. The Medical and Surgical Staff is divided into the following divisions:

1. Internal Medicine including departments of:
   a. Dermatology
   b. Cardiology
   c. Neuropsychiatry
   d. Pathology
2. General Surgery including departments of:
   a. Anesthesiology
   b. Otorhinolaryngology
   c. Ophthalmology
   d. Orthopedics
   e. Urology
   f. Neurosurgery
   g. Dentistry
3. Physical Medicine and Rehabilitation.
4. Radiology.

B. The division or department chiefs are chosen with the approval of the Medical Advisory Committee responsible to the chairman of the Joint Commission. They may be full time or part time All of them receive compensation for their duties. In accordance with the policy of the State Personnel Board full-time medical personnel do not engage in private practice or consultation for a fee.

C. Applications for staff appointment are open to all qualified physicians in the State of Connecticut. Applications are submitted to the Commandant of the Veterans Home and Hospital, after which they are reviewed by the head of the division or department concerned and submitted to the Medical Advisory Committee for approval.

III. Assignment to Duty:

A. The members of the Consulting, Attending and Associate Attending Staff are subject to call as requested by the head of the division concerned according to the policy of the Medical Advisory Committee and the chairman of the Joint Commission.

(Continued on page 210)

OBITUARIES

Harold Sears Arnold, M.D.

1877 - 1951



Harold Sears Arnold was born in New Haven July 29, 1877 to Captain George Sumner Savage Arnold, a merchant, and his wife, nee Evelyn G. Thomson of Hartford. Both his father's and mother's families were of good old Yankee stock, the Arnolds from Rhode Island and his maternal ancestors from Massachusetts and New Hampshire. He received his primary education at the Webster School in New Haven, spent three years at the Hillhouse High School, and then transferred to Phillips Andover Academy where he spent a year, graduating in 1896. During this period he doubtless exhibited some of the characteristics of his manhood: a lively interest in many things and a somewhat puckish sense of humor.

Dr. Arnold entered Yale College in 1896 and received his B.A. in 1900. During his college course it was necessary for him to partly pay his way which he did by singing in the college choir, acting as monitor, playing the 'cello, and doing photographic work. These extracurricular activities foreshadowed the hobbies of his later life, especially his pronounced interest in music. In addition to singing in the college choir, he was a member of the Apollo Glee Club, the University Mandolin Club, the University Glee Club, and the New Haven Symphony Orchestra. His continuing interest in music was evidenced by registration in the School of Music from 1925 to 1931, though he was not a candidate for a degree. For many years he played the violincello in the New Haven Symphony Orchestra, mostly under the leadership of his friend Horatio Parker. During his college years and later he was also a devotee of photography and his picture of the well known hatchet-wielding prohibitionist, Carry Nation, surrounded by a group of students, many of whom behind her field of vision grasped uplifted beer mugs, will always be a classic.

In 1900 Dr. Arnold entered the Yale Medical School where he was handicapped during his first and second years by attacks of abdominal pain and, as he himself described, an inferiority complex. An operation for removal of an enlarged, kinked and adherent appendix early in his third year abolished both symptoms and resulted in a great improvement in his scholastic record. His graduation thesis was based on the palatal measurements of a large number of skulls from "flathead" Indians and demonstrated that their peculiar method of deforming the cranium had no effect on the arch of the palate.

The summer following graduation Dr. Arnold spent as externe in pathology at the Presbyterian Hospital in New York and also took obstetrical training at the Sloane Maternity Hospital. Following this he served, from 1904 to 1906, as intern and house officer at the Hartford Hospital under Oliver C. Smith, Walter R. Steiner, and William Porter. The last named, an excellent clinician, made a strong impression on him. He then went to Europe for graduate study in Vienna and Berlin, especially in pediatrics and internal medicine. In Vienna he worked with Escherich and Schick and with Schmidt of Neusser's Clinic. In Berlin he took Heubner's lectures but devoted most of his time to pathology at the Moabit Hospital. These facts make it evident that he had an unusually broad training in his chosen profession.

After his return from Europe Dr. Arnold settled down to the practice of medicine in New Haven and built up a family clientele, his chief interest being in internal medicine. In 1920 he began work in the University Department of Health, first as a medical examiner and from 1921 until his retirement following an infarct in the right lung in November 1947 as medical examiner and assisting physician.

After his return from Europe he became associated with the Yale Medical School, from 1908 to 1910 as instructor in bacteriology and from 1908 to 1917 as instructor in pathology. When the headship of the Department of Pathology changed in 1917 the faculty did not reappoint the junior members of the staff in order to give the new professor, Milton C. Winternitz, a free hand in the appointment of his staff.

In 1908 Dr. Arnold became an assistant attending physician to the New Haven Hospital and in 1917 was elected an attending physician. In 1918 he was president of the Medical Board. He was one of the group who generously gave up their rights to ward services when the Yale Medical School went on the full time plan toward the close of World War I.

During the first World War Dr. Arnold was commissioned a first lieutenant in the Medical Corps in April '17. He was promoted to captain in August 1917 and to major in September 1918. In the early part of his service he was examiner for the engineer regiment at New London and in August 1917 was transferred to New Haven in charge of the Aviation Examining Unit. In March 1918 he was sent to U. S. Army General Hospital No. 16, later the William Wirt Winchester Hospital, in West Haven, and in July of that year he was sent out to Vancouver Barracks, Washington, to join the Tuberculosis Examining Board. Arnold regarded his work at Vancouver Barracks as a profitable though somewhat monotonous task. In October 1918 he wrote that he had completed the examination of his 4900th registrant and had detected overlooked tuberculosis in 102 examinees. His letters mention interesting experiences with patients suffering from neurocirculatory asthenia and refer to the devastating influenza epidemic with its secondary pneumonias, the latter apparently much less prevalent at Vancouver Barracks than in the civilian population of New Haven.

During his years of practice in New Haven Dr. Arnold was active in many interests outside of his professional work. He was secretary of the class of 1903 M. and was a vice-president of the Association of Class Secretaries in 1916; he was chairman of the executive committee of the Association of Yale Alumni in Medicine from 1929 to 1930; he was elected a member of the Committee on Admissions of the Graduates Club in 1919; he was treasurer of the Civic Orchestra Association in 1934 and vice-president in 1938-39. In 1934 he was a member of the Committee on Historical Exhibit for the celebration of the 150th Anniversary of the founding of the New Haven County Medical Association. When the Beaumont Medical Club was organized he became a member and contributed an interesting paper on "Bishop Berkeley and his Tar Water."

Meanwhile he had purchased a home in Woodbridge where he exhibited an active interest in "the birds, the bees, and the flowers," not to mention the vegetables and fruits. He revelled in the country life and it could truly be said of him, as of Walter Savage Lander: "Nature I loved and next to nature art; I warmed both hands before the fire of life."

Arnold's home life was a happy one. In 1913 he married Justine Ingersoll who bore him a son and two daughters. During his many years of incapacitating illness she was indeed a faithful helpmeet who lightened his burdens in many ways. He had many friends who visited him in his Woodbridge home during the years when he was "cribbed, cabined and confined." His courage and cheerfulness under his physical handicaps was admirable, and he never lost his sense of humor. He occupied his time by writing an interesting autobiography and snatches of poetry on various subjects which caught his fancy and which could be discussed in his humorous vein. We shall miss him, not only in his professional capacity, but as one who was a loyal friend and took a broad interest in public affairs.

George Blumer

Robert J. Cook, M.D.
1888 - 1951

The medical profession of the State of Connecticut and especially those of New Haven County regret the passing of Dr. Robert J. Cook. Born in Independence, Iowa on January 6, 1888, he graduated from the State University of Iowa in 1909 and received a medical degree from the Johns Hopkins University Medical School in 1913. From 1916 to 1918 he served as an assistant instructor at the Har-



vard Medical School and later as director of the School of Anatomy of the United States Army Medical Corps at Fort Oglethorpe, Georgia, from 1918 to 1920. He then was named assistant professor of orthopedics at Yale University on the Harriman Foundation. Before coming to New Haven he served as assistant surgeon at the New England Peabody Home for Crippled Children and as orthopedic clinical assistant in Boston's Children's Hospital.

In 1921 Dr. Cook was appointed orthopedic surgeon in the Department of University Health at Yale, which position he held until 1925. He then served as associate clinical professor of surgery in the School of Medicine until 1928 and was associate clinical professor of orthopedic surgery from 1928 to 1935.

Dr. Cook served all three hospitals in New Haven and the Griffin Hospital in Derby as well as other nearby hospitals. In addition to a very active practice, he served as a member of the New Haven Board of Aldermen from 1925 to 1929.

Dr. Cook held a Fellowship in the American College of Surgeons and was a Fellow in the American Medical Association and in the American Academy of Orthopedic Surgeons.

Dr. Cook is survived by his wife, the former Edith Moore Valet, and a daughter, Edith, a student at Wellesley College.

He was possessed of a retiring manner and apparently short in conversation. Nevertheless, he was deep in thought and understanding and most charitable to his patients. His kind understanding and good humor was masked by his oft time silence. In addition to a wealth of medical background and knowledge, he was profoundly interested in national and world wide affairs. His contribution to the field of orthopedics in Connecticut will long be remembered and his absence will long be felt.

A. Lewis Shure, M.D.

Red Cross Blood Program

The Red Cross is now operating 44 Regional blood centers drawing blood for both civilian and military use, 15 defense centers where collections are made exclusively for the military and more than 100 mobile units. In addition, twenty-three cooperating private blood banks are assisting in the procurement program. These facilities double those of World War II during which Red Cross collected more than 13,000,000 pints of blood for the Armed Forces.

More than a third of the nation's civilian, military, and veterans hospitals were being supplied with blood through the Red Cross Blood Program at the rate of 125,000 pints a month.

"Women Fail to Do Share in Blood Drive" is the title of a recent article by James Daniel in the *New York World Telegram*. He writes, "American women are letting down the drive for blood donations. The working girl is doing her part—holding her own with the men in donating blood for the Armed Forces. But from all over the country come reports that the leisure time ladies between 40 and 60 are deaf to appeals for blood donations. Nationally the proportion of women donors runs about 25 per cent. Since most blood donor centers operate chiefly while men are at work, there's no reason, officials say, why the proportion shouldn't be closer to 50-50. What makes some of the volunteers who do stick on the job angriest with their sex is the fact that the women with the fewest family obligations and often the greatest freedom from financial worries are generally the least interested. Red Cross officials say they don't expect all women to be able to make a blood donation, but after a woman has reached forty and her children are out from under foot, and if she's healthy . . . she's just as good donor material as a man."

Per cent of women donors in Connecticut, 26.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. F. Erwin Tracy, Middletown
President-Elect, Mrs. Barnett Freedman, New Haven
First Vice-President, Mrs. Ralph Ogden, West Hartford
Second Vice-President, Mrs. Dewey Katz, Hartford
Recording Secretary, Mrs. Arthur H. Jackson, Washington
Corresponding Secretary, Mrs. Harry C. Knight, Middletown
Treasurer, Mrs. William V. Wener, Norwich

State News

ART COMMITTEE

The annual Art Exhibition, held in conjunction with the State Medical Society meeting, April 29, 30 and May 1, will be hung at the Bulkeley High School in Hartford. Members of the Woman's Auxiliary, the Medical Society, and children of members are invited to exhibit. Entries are limited to two per person, and a hanging fee of $2 will be charged the adult exhibitors. Pieces in the following media will be accepted: oil, water-color, pastel, prints, tempera, photography, sculpture and marquetry.

Members interested in exhibiting are asked to contact the following local art chairmen for further details:

Fairfield County: Mrs. John Maher, 2184 Main Street, Stratford.

Hartford County: Mrs. Edward H. Crosby, 252 Edgewood Street, Hartford.

Litchfield County: Mrs. Lincoln Opper, 598 East Main Street, Torrington.

Middlesex County: Mrs. Joseph Magnano, 100 Broad Street, Middletown.

New Haven County: Mrs. Bernard Brody, Hilltop Road, Hamden.

New London County: Mrs. Edward Comstock, Starr Hill Road, Groton.

Windham County: Mrs. Cecil R. Garcin, 11 Broad Street, Danielson.

Diane Marinaro, Chairman

TODAY'S HEALTH

The annual *Today's Health* subscription drive, sponsored by the American Medical Association, is drawing to a close. Returns are still incomplete but already we have obtained more subscriptions than in past years.

Most counties have made a slow but steady progress. The Fairfield County drive, under the direction of Mrs. Clifford Moore, had an exceptional upswing in subscriptions sold.

Mrs. Joseph Epstein, *Today's Health* chairman in Middlesex County, was the first to reach her quota. This county has made its quota for two years in succession.

Mrs. Richard V. Newcombe, *Today's Health* chairman in Windham County, reports that Windham has made its quota.

All counties have been working hard, getting the doctors acquainted with our *Today's Health* program.

The employees of the Connecticut Medical Service have received a one year's subscription to *Today's Health*, through the courtesy of the Connecticut Medical Service.

Dolly Buckley, Chairman

County News

FAIRFIELD

Two Nurses' Scholarships were approved by the county this year. Applications are now being received by the chairman. This scholarship is given with the understanding that the chosen girl remain in training and graduate. The first of our county girls to use the plan graduates this year.

The piano purchased and put on rollers for easy moving from one ward to another has been delivered and is being used to great advantage at Laurel Heights.

A gift wrapping contest held at Christmas gave each patient a beautifully wrapped gift. New Canaan Junior Red Cross filled individual jelly glasses with homemade jelly for the breakfast tray of each patient. Additional phonograph records were bought and books to replace the old ones now in use.

School Health plans in all parts of the county are being carried out. The aim is to have a standardized form for health examinations, which include the family physician's name, for all schools in Fairfield County.

NEW HAVEN

The Auxiliary sponsored a fashion show on Friday evening, January 7. Everyone who attended donated to the Nurse's Scholarship Fund. The show featured cruise and summer clothes as shown in the January *Harper's Bazaar*.

Mrs. Nicholas La Femina, chairman of the Fund, was assisted by the following: Mrs. Francis Albis, Mrs. M. J. Carl Allinson, Mrs. Charles Culotta, Miss Mildred Cronin, Mrs. Alphonse Gencarelli, Mrs. Gabriel Ingenito, Mrs. Samuel Jaffe, Miss Jane Lawn, Mrs. Michael La Vorgna, Mrs. Donald Moore, Mrs. Joseph Mignone, Mrs. Charles Petrelli, Mrs. Walter Radowiecki, Mrs. Bernard Swan, Mrs. Charles Schollhamer, Mrs. Raymond Zagraniski. The following served as models: Mesdames Eugene Clifton, Reginald Gillson, Samuel Jaffe, A. L. Kay, Robert Lowman, Donald Moore, P. A. Piccolo, William Riordan, Melchior Saverese, Paul W. Vestal.

Proceeds for the project amounted to $254.80. Mrs. Stanley Bogunieckí announced a total of $51.20 received for the Nurse's Scholarship Fund from a recent Bake Sale.

The annual Christmas Gift Campaign for the State Hospitals at Middletown and Newtown was under the leadership of Mrs. Donald Moore. Collection depots scattered throughout New Haven brought in hundreds of gifts. Girl Scouts also were contributors. In Meriden Mrs. J. Alfred Wilson headed the collection. Other chairmen were: Mrs. Chris Neuswanger, Watertown; Mrs. John Renehan, Ansonia.

State Veterans Hospital Outline of Staff Organization (Continued)

B. Members of the full-time staff may call any member of the Attending or Consulting Staff in case of emergency without approval of the divisional chief, but in general such calls are made only with the approval of the Chief of Medicine or Chief of Surgery.

IV. Hospital Professional Staff Orzanization:

The Hospital Professional Staff at present consists of:

A. The Hospital Administrator (Chief Medical Officer), Hospital Executive Officer and staff.

B. The Chief of Medicine.

1. The Chief of Medicine is responsible for the care of patients on the medical wards and has administrative jurisdiction over the following departments:
   a. Dermatology
   b. Psychiatry
   c. Neurology
   d. Pathology
2. He has to assist him:
   a. Three senior physicians.
   b. One assistant physician.
   c. One resident in medicine.
   d. Four internists (part-time).
   e. The pathologist (part-time).
   f. Adequate consultants and attendings in all branches of internal medicine.
3. He supervises the teaching program for students, residents and consultants in the above departments and sections. He supervises medical records for his department and the medical library.
4. He conducts medical department staff meetings, teaching ward rounds, medical department death reviews, medical chest clinics and clinico-pathological conferences.

C. The Chief of Surgery.

1. The Chief of Surgery is responsible for the care of patients on the surgical wards and has administrative jurisdiction of the following departments:
   a. Anesthesiology
   b. Otolaryngology
   c. Ophthalmology
   d. Orthopedics
   e. Urology
   f. Neurosurgery
   g. Dentistry
2. He has to assist him:
   a. One senior physician.
   b. One assistant physician.
   c. One resident in surgery.
   d. The anesthetist.
   e. Two dentists and staff of technicians.
   f. Adequate consultants and attendings in all branches of surgery.
3. He supervises the teaching program for students, residents and consultants in the above departments and sections. He supervises surgical records for his department.
4. He conducts surgical department staff meetings, teaching ward rounds and surgical department death reviews.

D. The Chief of Physical Medicine and Rehabilitation and staff.

E. The Radiologist and staff.

F. The Chief Nurse and nursing staff.

G. The Chaplain.

H. The Director of Social Service.

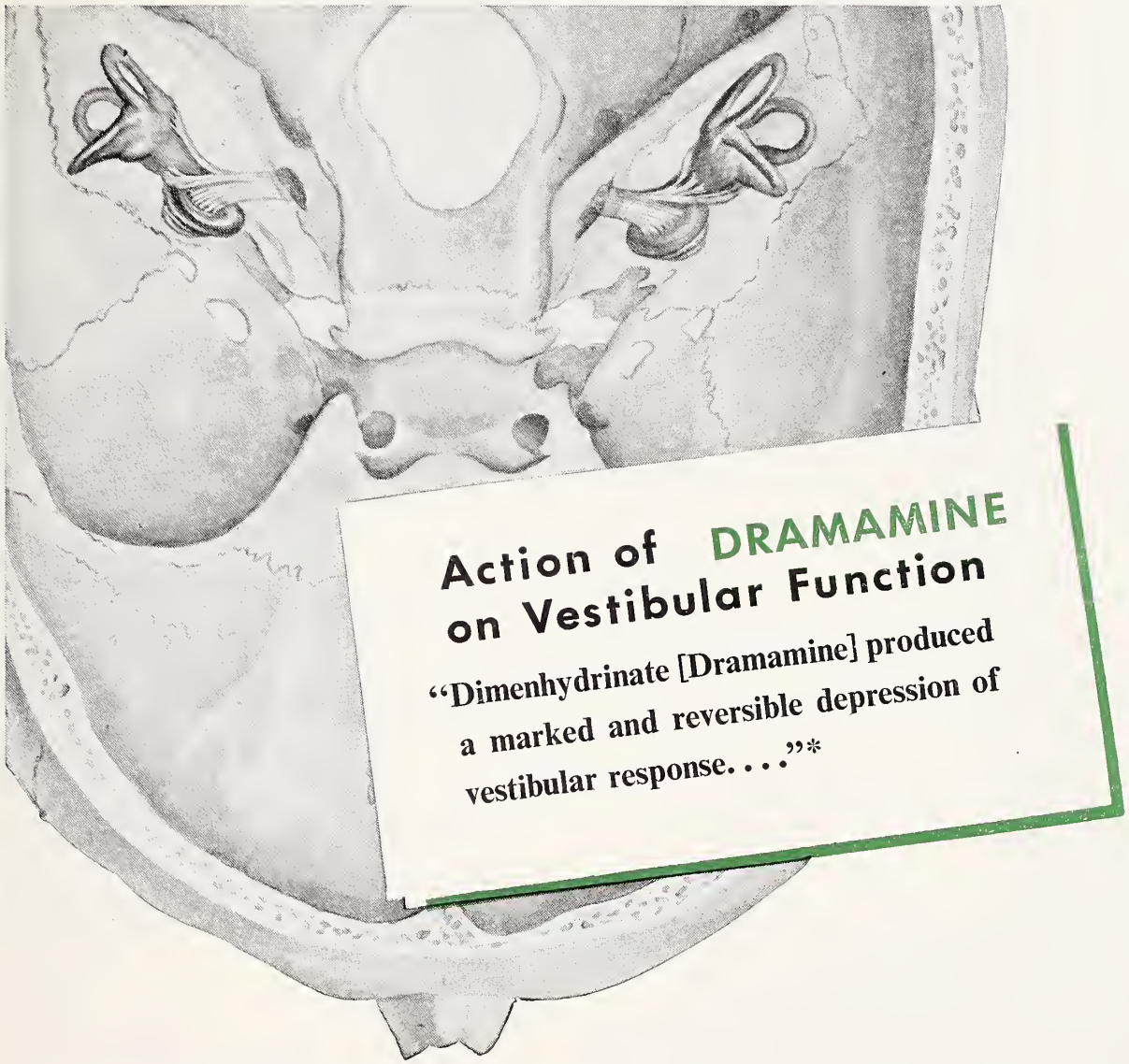
I. The Director of Educational and Vocational Guidance and staff.

J. The Consultant in Public Relations.

K. The Record Librarians and staff.

L. Two Pharmacists.

(Continued on page 214)



Action of DRAMAMINE on Vestibular Function

"Dimenhydrinate [Dramamine] produced a marked and reversible depression of vestibular response. . . ."*

In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milliamperage necessary to effect tilting."

The great effectiveness of Dramamine in motion sickness, they state, ". . . is probably related primarily to its ability to depress vestibular function. . . ."

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for prevention and treatment of motion sickness—

Now available in these dosage forms: { Tablets — 50 mg. / Liquid — 12 mg. per 4 cc. / Average dose — 50 mg.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

SPECIAL NOTICES

HARTFORD HOSPITAL MEDICAL EDUCATION PROGRAM

Saturday Mornings, 11 o'clock
Hartford Hospital Amphitheater
80 Seymour Street, Hartford, Connecticut

March 1

Thomas M. Durant, M.D., professor of clinical medicine, Temple University School of Medicine

The Anginal Syndrome

March 8

Louis Welt, M.D., assistant professor of medicine, Yale University School of Medicine

The Role of the CNS in the Metabolism of Electrolytes and H_2O

March 15

Joseph N. D'Esopo, M.D., associate clinical professor of medicine, Yale University School of Medicine

Basilar Tuberculosis

March 22

Preston Wade, M.D., associate professor of clinical surgery, Cornell University Medical College

The Do's and Don'ts of Fracture Treatment

March 29

Samuel Proger, M.D., professor of medicine, Tufts Medical School; President, Bingham Foundation

Lipids and Atherosclerosis

April 5

Thomas H. McGavack, M.D., professor of clinical medicine, New York Medical College

Hyperthyroidism

April 12

Eugene C. Eppinger, M.D., assistant professor of medicine, Harvard Medical School; assistant dean in charge of postgraduate education, Harvard Medical School

Studies in Congenital Heart Disease

April 19

E. Myles Standish, M.D., attending dermatologist, Hartford Hospital

Dermatology (Kodachrome slide presentation)

April 26

M. H. Cottle, M.D., professor of otolaryngology, Chicago Medical School

Restoration of Nasal Function

May 3

S. J. Thannhauser, M.D., emeritus professor of clinical medicine, Tufts College Medical School

Case presentation

May 10

Perry P. Volpitto, M.D., professor of anesthesiology, University of Georgia

Amnesia, Anesthesia and Analgesia in Obstetrics

May 17

Lewis Diamond, M.D., associate professor of pediatrics, Harvard Medical School; medical director, Blood Program, American Red Cross

Changing Trends in Pediatrics

May 24

J. Lawrence Pool, M.D., professor of neurosurgery, Columbia College of Physicians and Surgeons

Early Diagnosis of Benign Brain Tumors

May 31

Symposium on Glaucoma, Hartford Hospital Department of Ophthalmology

June 7

Cushman Haagensen, M.D., associate professor of surgery, Columbia College of Physicians and Surgeons

Treatment of Breast Carcinoma

CONNECTICUT VA MEDICAL SOCIETY

The medical conferences of the Connecticut Veterans Administration Medical Society will be held during March 1952, at 3:30 P. M., on the dates listed below, at 95 Pearl Street, Hartford, Connecticut

March 6

Francis J. Ryan, M.D., chief of medical service, Veterans Administration Regional Office, Hartford

Discussion with film on Kidney Function in Disease, courtesy of Lilly Research Laboratory

March 20

Paul Twaddle, M.D., director of cardiology, Hartford Hospital, Hartford

Congestive Heart Failure

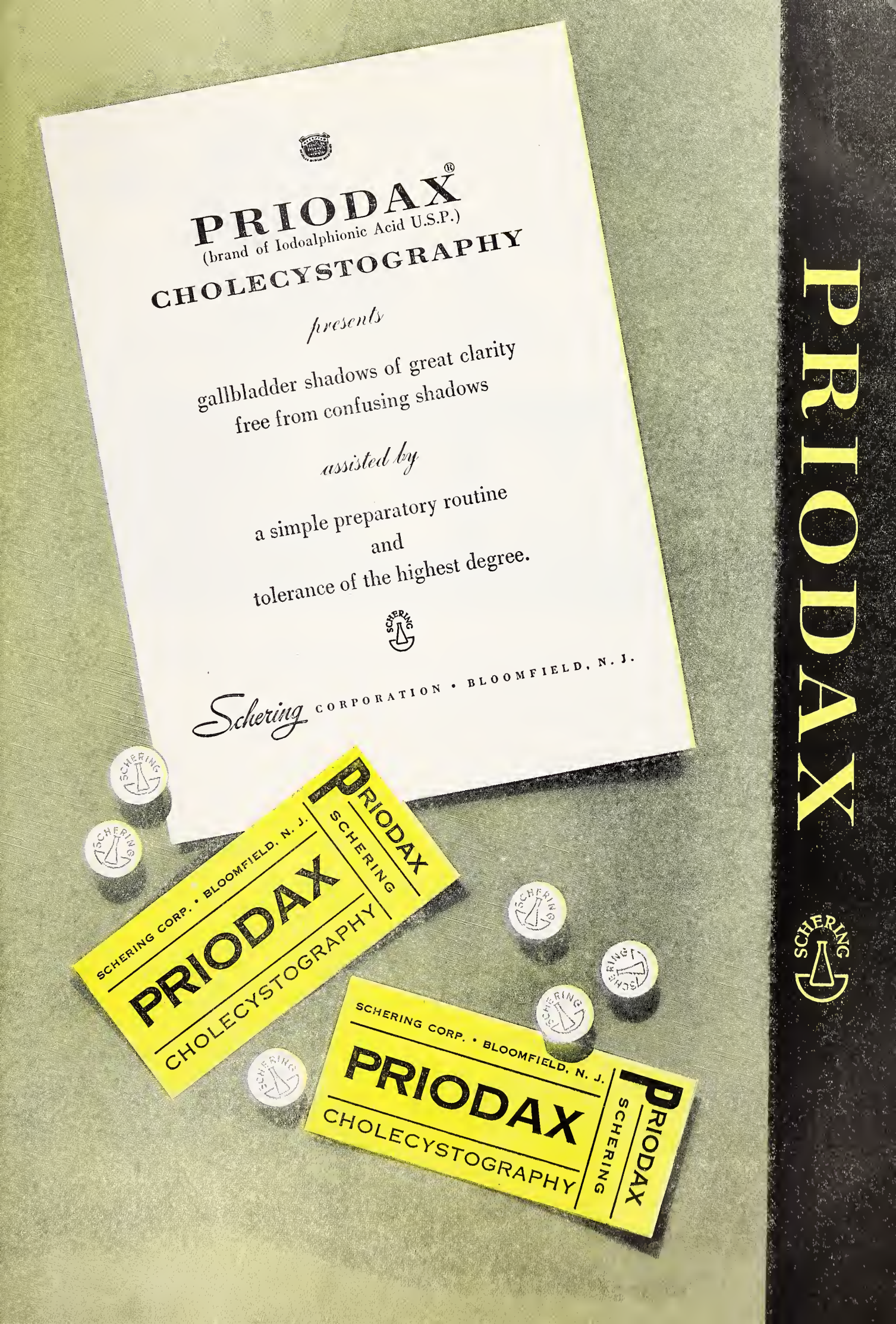
March 27

Robert Levin, M.D., associate physician, Veterans Administration Regional Office, Hartford, and clinical assistant, Mt. Sinai Hospital, Hartford

Discussion on Cortisone Therapy with case reports

CONFERENCE ON MATERNAL MORTALITY

The Committee to Study Maternal Mortality and Morbidity of the Connecticut State Medical Society will present a conference on maternal mortality before the Hartford Hospital Obstetrics and Gynecology Clinic at 10:00 A. M. on Saturday, March 15. The conference will be held in the amphitheater of the hospital and is open to all physicians interested in the care of maternity patients.


PRIODAX®
(brand of Iodoalphionic Acid U.S.P.)
CHOLECYSTOGRAPHY
presents
gallbladder shadows of great clarity
free from confusing shadows
assisted by
a simple preparatory routine
and
tolerance of the highest degree.
SCHERING
Schering CORPORATION • BLOOMFIELD, N. J.
SCHERING CORP. • BLOOMFIELD, N. J.
PRIODAX
CHOLECYSTOGRAPHY
PRIODAX
SCHERING
SCHERING CORP. • BLOOMFIELD, N. J.
PRIODAX
CHOLECYSTOGRAPHY
PRIODAX
SCHERING
PRIODAX
SCHERING

HEART SYMPOSIUM

Thursday, March 13, 1952, Waterbury Hospital

Presented by Waterbury Heart Association, Inc., and Waterbury Hospital at the hospital.

12:00 I—"CorPulmonale"

Lewis Dexter, M.D., assistant professor of medicine, Harvard University School of Medicine.

1:15 Lunch at Hospital (50 cents)

2:00 II—"Constrictive Pericarditis"

Charles Sidney Burwell, M.D., research professor of clinical medicine, Harvard Medical School, attending physician at Peter Bent Brigham Hospital

III—"Mitral Stenosis and Insufficiency"

Lewis Dexter, M.D.

POSTGRADUATE COURSE IN PULMONARY FUNCTION

The American Trudeau Society, Medical Section of the National Tuberculosis Association, announces a Postgraduate Course on "The Measurement of Pulmonary Function in Health and Disease" to be sponsored by the Medical Schools of Harvard University, Tufts College, and Boston University, and to be held at the Boston Medical Library March 24-28, 9:00 A. M. to 5:00 P. M. daily.

This is a beginner's course aimed at physicians interested in diseases of the chest who wish to acquaint themselves with the ABC's of methods used in the evaluation of pulmonary function. Methods of analysis of pulmonary function and related cardiac function will be described. Actual hospital demonstrations of tests with patients will be carried out.

Tuition fee is $50. Applications and more detailed information may be obtained from Edward J. Welch, M.D., chairman, Regional Committee on Postgraduate Courses, 1101 Beacon Street, Brookline 46, Massachusetts.

Tuberculosis Associations in Connecticut will provide a limited number of scholarships upon request. Information regarding scholarships may be secured through Mabel Baird, executive secretary, Connecticut Tuberculosis Association, 43 Farmington Avenue, Hartford, telephone 7-9206.

MASSACHUSETTS ASSOCIATION OF MEDICAL TECHNOLOGISTS

Seminar, Boston Medical Library, March 28-29. All medical technologists urged to attend.

Fourth Annual Meeting, Hotel Somerset, Boston, May 3.

NEW ENGLAND HEALTH INSTITUTE

The 18th New England Health Institute will be held at the University of Connecticut, Storrs, June 18-20. The Institute is being sponsored by the Connecticut State Department of Health and the University of Connecticut, also 31 other agencies from New England as well as the U. S. Children's Bureau and the U. S. Public Health Service.

GRADUATE SEMINAR IN HEALTH EDUCATION

During the 1952 summer session, the Department of Education of Yale Graduate School with the cooperation of the Yale Department of Public Health and numerous official and voluntary agencies concerned with education and health will offer a graduate seminar in School Health Education.

The Seminar is designed to meet the needs of elementary and secondary school teachers and administrators.

Tuition for the summer session is $120 payable in full at the time of registration.

Applications should be addressed to Clyde M. Hill, chairman, Department of Education, Yale University.

State Veterans Hospital Outline of Staff Organization (Concluded)

M. The Chief Dietitian and staff.

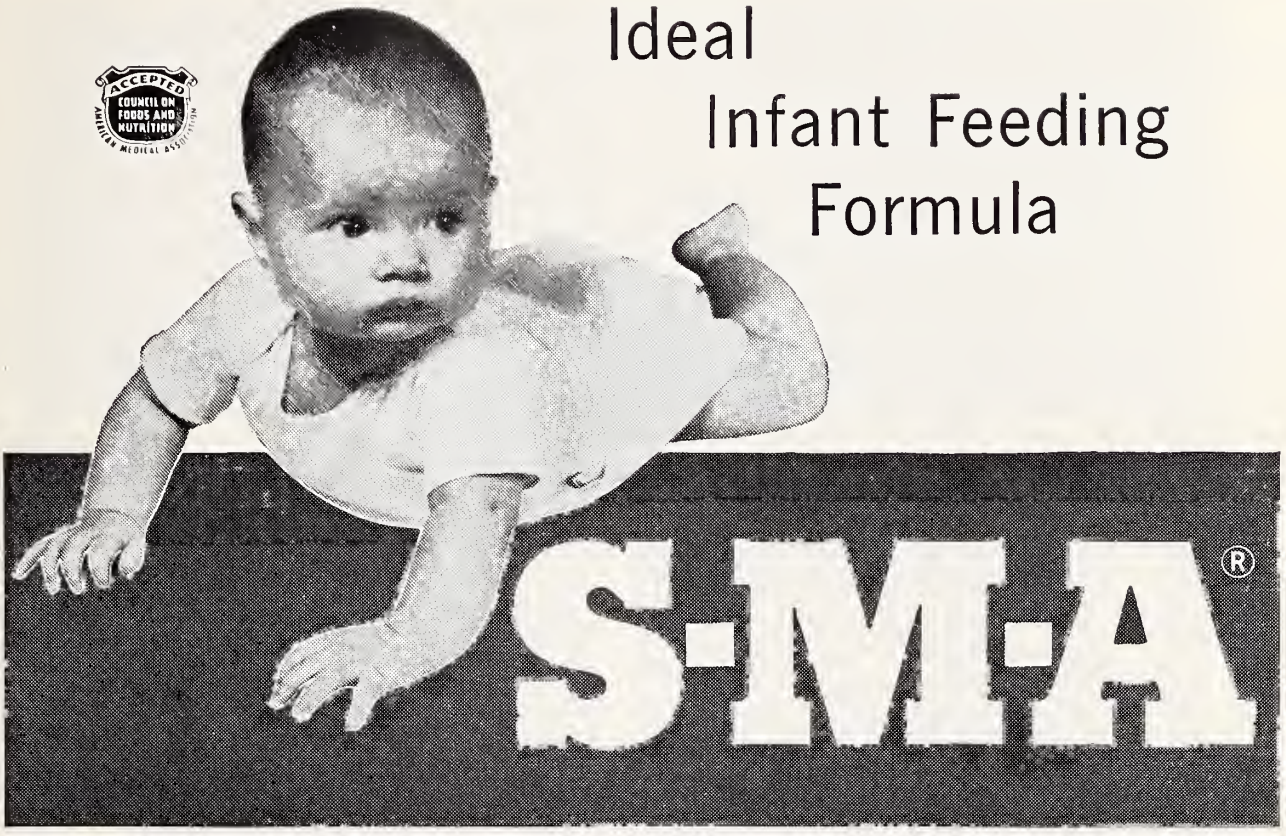
N. The following positions previously recommended have been established, but are not filled at present:
1. One senior physician and two assistant physicians.
2. Three residents in medicine.
3. Four assistant residents in medicine.
4. Three residents in surgery.
5. Eight interns.
6. One dental hygienist.

V. Ward Management:

A. Each of the fourteen wards is under the direct charge of a senior physician or assistant physician. Assignments to wards 2A, 2B, 2C, 2D, 3B, 3C, 3D, 4A, and 4B are made by the Chief of Medicine. Assignments to wards 4C, 4D, 5C, and 5D are made by the Chief of Surgery.

VI. Administrator of Clinical Services:

A. The coordination of Clinical services is the direct responsibility of a Clinical Director who acts as:
1. Chairman of the Medical Advisory Committee which meets quarterly.
2. Chairman of the Hospital Council which shall meet as he deems necessary, and which consists of:
   a. The hospital administrator.
   b. The hospital executive officer.
   c. The chief of medicine.
   d. The chief of surgery.
   e. The chief of physical medicine and rehabilitation.
   f. The chief nurse.
3. Chairman of the Medical and Surgical Staff Meetings held bi-monthly.
4. Chairman of the Wednesday morning weekly Evaluation Clinic.



Ideal Infant Feeding Formula

S-M-A®

S-M-A is a complete formula.

Unmatched in similarity to healthy mother's milk, S-M-A provides all essential food elements, including vitamins and minerals well in excess of recommended daily allowances.

S-M-A is an economical formula.

Only water need be added. Since the addition of nutritive elements is unnecessary, *the initial cost is the whole cost*. And the whole cost of the complete S-M-A formula is *less than 1¢ per ounce.*

S-M-A Liquid **S-M-A** Powder

Wyeth® *Wyeth* Incorporated, Philadelphia 2, Pa.

OUR NEIGHBORS

New Jersey

The Public Health Council of the New Jersey Department of Health recently went on record unanimously as favoring abolition of the "means test" for admission of patients to public tuberculosis sanatoria. By this test patients or their responsible relatives have been required to pay all or some portion of the costs of their care, unless they are destitute. Many factors entered in to this decision by the Public Health Council, among them being the fact that most of the cost of care in public institutions is now borne by taxation, and also the fear of and worry over costs acting as a hindrance to proper medical care in the case of many ill persons.

* * * *

Through the efforts of Dr. Hilton S. Read of Atlantic City, a private agency has been formed and is supervising exchange training for 28 young German physicians in New Jersey. These recent medical school graduates from Germany are spending 16 months as interns in various New Jersey community hospitals. They are paid regular stipends averaging $100 a month. From this the cost of their passage has been deducted. Several individuals and groups have supplemented this meager sum remaining with gifts of various kinds. Added to the medical training acquired by these German physicians is an invaluable opportunity to gain a first hand knowledge of life in a democratic society.

New York

The New York County Medical Society began a presentation of medical information to the general public in a series of television programs on February 10 on National Broadcasting Company facilities.

The series will be produced in cooperation with NBC on a sustaining basis, for the present, and will be called, "Here's To Your Health." It will be one of the most ambitious efforts to reach the public ever made by the medical society, largest county organization of its kind in the country. It will also be the first national network series presented by a medical society.

The telecasts will be presented in documentary-drama form and will originate in hospitals, laboratories and research centers. Specialists in the field under discussion will participate in each program, at the invitation of the society. Authenticity of the medical and scientific information to be telecast will be guaranteed by the society which will closely supervise the subject matter.

Dr. Lester L. Coleman, a member of the New York County Medical Society and originator of the program, will supervise the series.

The plan originated with the medical society last March when it was officially approved at a meeting attended by 400 of the 7,000 members. A test kinescope was made last summer. NBC is seeking a sponsor for the program, but the society has rigid control over the choice. Because of professional ethics, the society would prefer a sponsor not associated with the medical field, it was learned.

* * * *

Columbia University College of Physicians and Surgeons has established a new Department of Anesthesiology with Emanuel M. Papper, professor of anesthesiology at the College, the executive officer. As an independent department with a faculty of thirteen, the unit's research into anesthetics and the process of anesthesia will be enlarged and in addition it will continue to provide instruction for each medical student.

NEWS
from County Associations

Fairfield

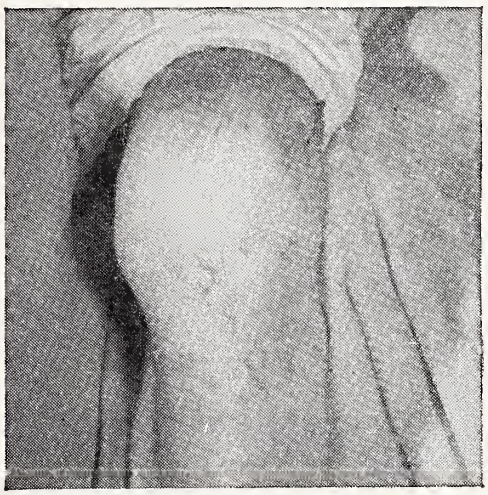
Attending the meeting of the American Academy of Orthopedic Surgeons in Chicago in January were Arthur S. Griswold, Edward P. McCreery, Luther M. Strayer and Philip L. Staub of Bridgeport.

The regular meeting of the Bridgeport Medical Association was held in the auditorium of St. Vincent's Hospital on February 5. The speaker was John B. O'Connor, assistant clinical professor of medicine at the Yale School of Medicine and senior sanitarium physician at the Laurel Heights Sanitorium. Dr. O'Connor spoke on, "Current Status of Chemotherapy in Pulmonary Tuberculosis."

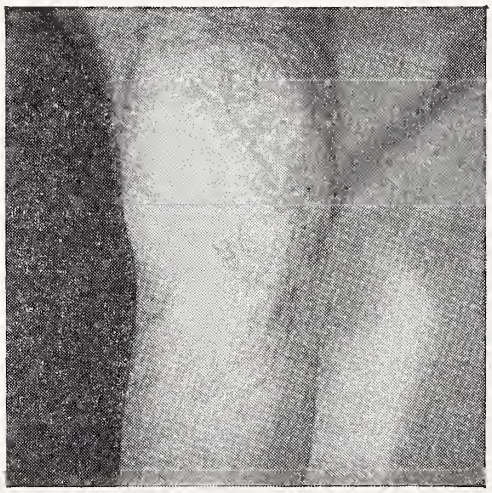
The Medical Advisory Committee of the Fairfield County Medical Association to the Fairfield County Chapter of the Infantile Paralysis Foundation recent-

Cortone®

Can be used Safely in the Prolonged Control of Rheumatoid Arthritis



BEFORE TREATMENT:
Periarticular swelling and hydrarthrosis



AFTER TREATMENT:
Diminution of pain, increased mobility, and visibly decreased effusion and swelling

Rehabilitation Achieved Through Conservative Dosage

Management in Everyday Practice

The use of simple laboratory tests (sedimentation rates, urinalyses, blood counts, blood pressure, and frequent weight recordings), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

Effective Antirheumatic Response

Effective antirheumatic response was achieved in all 100 patients in a long-term study at the Mayo Clinic. More than 50 of these arthritics were maintained on 50 mg. or less daily. In no case was it necessary to withdraw the hormone.

Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

Literature on Request

Cortone®
ACETATE
(CORTISONE Acetate Merck)

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

ly was reorganized and now consists of Oliver L. Stringfield as chairman, John B. Booth, Benjamin W. Bullen, Harold Ribner, Maxwell Bogin, Francis P. Williams, Louis Castaldo.

Berkeley M. Parmelee attended the meeting of the American College of Radiology in Chicago in February.

Francis B. Woodford and Theodore Safford, Jr. of Ridgefield have been appointed as deputy and alternate deputy medical coordinators in the Ridgefield area by C. Fred Yeager the coordinator of health services of the Bridgeport Civil Defense Council.

The annual meeting of the Fairfield County Medical Association will be held at the Stratfield Hotel in Bridgeport on Tuesday, April 8, 1952, the business meeting in the afternoon at 4:30 and the annual dinner in the evening at 7:00 P. M. Each member registered at the annual meeting will receive dinner without charge. The program committee has secured Alex Raymond, famous cartoonist who will give a talk on, "Significance of the Comic Strip in Today's Society." Mr. Raymond is the originator of such famous cartoon strips as, "Flash Gordon," "Jungle Jim," and "Rip Kirby," the latter appearing in 450 newspapers in 20 countries and 10 languages. He was awarded the Billy DeBeck award as the outstanding cartoonist for the year 1949 and has served as president of the National Cartoonists Society for the years 1950 and 1951. He also is cocreator of the cartoon strip "Secret Agent X-9" with Dashiell Hammett. His talk promises to be very stimulating and entertaining.

Stewart G. Wolf, Jr., associate professor of clinical medicine at Cornell University Medical College in New York, addressed a combined lay physician assembly at the Burroughs Public Library in Bridgeport on Monday, February 11 on the subject, "New Hope for Hearts." The meeting was sponsored by the Bridgeport Medical Association and the Bridgeport Heart Association. Allen F. Delevett of Bridgeport presided as president of the Bridgeport Heart Association.

Louis Newton of the obstetrical staff of Bridgeport Hospital returned recently from a vacation in Florida.

J. Howard Staub, M.D. has retired as chairman of the medical board and as chief of staff of the Stamford Hospital. Dr. Staub has held both positions since 1937.

Allan M. Ross of Darien has been appointed medical examiner for that town, succeeding Ralph W. Crane of Stamford.

Sidney Beck was elected president of the medical and surgical staff of St. Vincent's Hospital, Bridgeport at the annual dinner in January. Other officers elected were Frank Turchik, vice-president, and Michael Brodsky, secretary.

Hartford

Matthew H. Griswold, chief of the Division of Cancer and Other Chronic Diseases of the Connecticut State Department of Health, was elected president of the Public Health Cancer Association recently at its meeting in San Francisco. Dr. Griswold was vice-president last year and previously was chairman of the Association's executive committee .

The new officers of the medical and surgical staff at Mt. Sinai Hospital, Hartford, are Morris Radin, president; Manuel Hershberg, vice-president; Louis H. Gold, secretary; Israel Beatman, treasurer. An association was formed at the annual meeting to raise money for expansion of the hospital's facilities, particularly the educational training program for young physicians and nurses.

Litchfield

The mid winter meeting of the Litchfield County Medical Association was held at the Charlotte Hungerford Hospital on Thursday, January 24, 1952. The meeting was preceded by a luncheon served in the hospital dining room. Creighton Barker, executive secretary of the Connecticut State Medical Society, spoke briefly concerning plans for the annual meeting to be held in Hartford. James Burch and William G. H. Dobbs reported as to the Educational Campaign. William Horton brought greetings from the Connecticut Medical Service.

Louis Garston, president of the Association, reported for the Executive Committee and there followed some discussion as to the advisability of incorporating the Association. Inasmuch as there was a comparatively small attendance at this meeting, it was decided to bring the matter of incorporation up for further discussion and action at the annual meeting in April.

John N. Gallivan, medical director of the United Aircraft Corporation, was the principal speaker. The subject of his most interesting talk was "Trends in

Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

Prescription Perfect



RED LABEL • BLACK LABEL
Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.



Born 1820 . . . still going strong

JOHNNIE WALKER
BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

Industrial Medicine." Dr. Gallivan traced the growth of this specialty to its present important status in the general medical scheme. He stressed the importance of organized medicine continuing its interest in this field and felt that it should play an important part in shaping its destiny. A very interesting discussion followed Dr. Gallivan's paper, during which numerous problems facing organized medicine and the industrial physician were aired.

Middlesex

Vincent J. Vinci spent several days in Boston visiting surgical clinics during the first week in February.

Francis E. Korn was married to Clara F. Hopwood on February 23 in Wethersfield. He is a graduate of the New York Medical College, interned at Middlesex Hospital and now practises in Durham. Mrs. Korn is an R.N. She trained at Middlesex Hospital and is at present head nurse in the hospital's operating room.

The Central Medical Association of Middletown had its annual dinner meeting at the Monte Green Inn on January 31. New officers were elected for the coming year. They are: President, Louis Soreff; Vice-President, Walter N. Nelson; Secretary, Julius H. Grower; Treasurer, Aldo Santiccioli. The speaker of the evening was Sigmund Neumann, professor of social sciences at Wesleyan University. He spoke on "Our World Today: A Diagnosis."

New Haven

Albert E. Hermann is the new president of the medical and surgical staff at St. Mary's Hospital, Waterbury. The other officers elected were P. J. Brennan, chief of staff (re-elected); William Finkelstein, vice-president; and Anthony L. Carpentieri, secretary.

Louis E. Cooper of New Haven, former medical examiner for Ansonia, died February 5 at the age of 90 in a convalescent home in Seymour. Dr. Cooper practiced in Ansonia for 42 years, retiring about 20 years ago.

Windham

On January 28, John Jarvis Russell died at his home in Putnam at the age of 85. Dr. Russell had been medical examiner in Putnam for 40 years and for 63 years a practitioner of medicine.

News from Yale University School of Medicine

Paul B. Beeson of Atlanta, Georgia has been appointed Ensign Professor of Medicine, succeeding Francis G. Blake as chairman of the Department of Internal Medicine at Yale. Dr. Beeson comes to Yale in the spring when he will assume the position of physician in chief of the University Service in Grace-New Haven Community Hospital.

On January 25 Girolamo Bonaccolto was the guest speaker at the Yale University School of Medicine Postgraduate Courses in Ophthalmology. His subject was "Surgical Technique of Extraction of Dislocated Lens" with illustration in colored film. Dr. Bonaccolto is clinical professor of ophthalmology, Post-Graduate Medical School, New York University-Bellevue Medical Center; surgeon, Manhattan Eye, Ear and Throat Hospital; attending ophthalmologist, St. Clare's Hospital, Columbus Hospital; consulting ophthalmologist, Mother Cabrini Memorial Hospital.

NEW BOOKS IN REVIEW

TEXTBOOK OF REFRACTION. By Edwin Forbes Tait, M.D., PH.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals. *Philadelphia and London: W. B. Saunders Company.* 1951. 418 pp. with 93 figures. $8.

Reviewed by HENRY L. BIRGE

This fine text book on refraction is dedicated to Charles Sheard, PH.D., great teacher of optics at the Mayo Clinic.

It begins by stating the place of refraction in the medical world. "There are few individuals who will not require, eventually, some assistance in the form of lenses."

Errors of refraction—or the failure of the ocular focusing apparatus, are separated from diseases of the eye and the visual nervous system, as they must be. Faulty coordination of the two eyes, as well as errors of interpretation such as "mirror writing" are considered.

The clear exposition in Chapter II makes easy understanding of the basic concepts and common tools used in refraction.

The refractive changes in the various types of accommodation are discussed in Chapter III and IV and the reasons for various abnormalities are clearly stated.

CAMEL—
America's most popular cigarette

_leads all other brands by billions!



Hyperopia, myopia, and astigmia are each given one chapter and are clearly described from the standpoint of definition, diagnosis and the author's belief regarding treatment.

Brief but adequate coverage is given presbyopia and aphakia, as well as aniseikonia and anisometropia. Helpful comments based on the author's experience are interspersed throughout the factual material of the text.

Glasses for hemianopic vision and others for ptosis are described, together with telescopic spectacles.

Almost 160 pages are devoted to *binocular vision*, including the physiology of the extraocular muscles and their reflex stimulations, anomalies and treatment.

This over emphasis on binocular vision is progress in the right direction, because too many refractionists pay but cursory attention to the intricate mechanisms involved.

While it is not possible to say that the majority of opthalmologists agree with the author in his belief that the keratometer is an indispensable instrument for refraction, it is worth while to study his methods of refraction.

He over emphasizes the importance of refraction without drops, probably because he is more expert in this technique. He feels that skiascopy under cycloplegia is more difficult than without cycloplegia, whereas most ophthalmologists believe the difficulty is less with cycloplegia. Refraction of children without cycloplegia is difficult and uncertain, and this subject is not covered in this text. However, the broad coverage of refractive methods make a study of this text eminently worthwhile. The expert refractionist must be able to use many methods to arrive at the proper answer.

Some text books present more bias than others, hence the value of a broad medical education and experience. Technical speed, efficiency and accuracy, seasoned with psychosomatic philosophy can only be acquired by experience.

Chapter XXIII is devoted to Dr. Tait's great interest, namely, dynamic skiascopy (retinoscopy) at the near point. He has perfected a very satisfactory system, but most ophthalmologists prefer other methods of skiascopy because of the ease of controlling the great variable factor, accommodation, by cycloplegic drugs. Dr. Tait lists no disadvantages to his system.

Refraction must be considered as only a portion of an ophthalmic examination. Medical problems discoverable with the ophthalmoscope, neurologic problems, especially in visual fields, local eye diseases, especially tonometry, make up the value of a medical ophthalmologic examination.

If one views eye examinations as chiefly a refraction problem a distorted picture of eye work results. This book is only recommended, therefore, to those who already possess a broad knowledge of ophthalmology and the ability to determine what tests are best suited in each individual patient.

STATISTICS FOR MEDICAL STUDENTS AND INVESTIGATORS IN THE CLINICAL AND BIOLOGICAL SCIENCES. By Frederick J. Moore, M.D., *Frank B. Cramer,* B.A., and *Robert G. Knowles,* M.S. *Blakiston Company.* 1951. 113 pp., 11 figures, 16 tables. $3.25.

Reviewed by JOHN S. NICHOLAS

At the present time statistics has become an accepted routine for much of the work in biological research. Its impress upon the modern period is clearly given in the brief preface of this very handy little compendium of statistics for medical students.

For those of us who received our training in the days when statistical treatment of results was not nearly so current, this may seem an additional burden to a medical student's reading. It is, however, applicable not only to them but to physicians in practice as well as those who are dealing with quantities of material which demand the consideration of variation.

The book itself is a simple treatment of the fundamentals which are necessary to understand: (1) variation, (2) normal curves, (3) sampling of distributions, (4) the analysis of non-normal distributions, and (5) the general aspects of the design of experiments and presentation of results. The book is limited to a discussion of these five points and contains in addition an appendix of tables which anyone who is constructing curves will find useful. The material is clearly and logically presented in as simple a form as can be done. It has a minimum of calculations and shows the easy methods by which such formulations can be transferred, either through tables or by means of curves. It also shows the reverse in that the curves themselves can be reduced mathematically to fairly simple formulae. This will be particularly applicable to the small minority of the biological profession which is peculiarly gifted along the mathematical side. This book is an exceedingly valuable aid and reduces the statistical analysis to a simple and understandable form.

CLINICAL PEDIATRIC UROLOGY. By Meredith Campell, M.S., M.D., F.A.C.S., Professor of Urology, New York University Post-Graduate Medical School. With a section on *Nephritis and Allied Diseases in Infancy and Childhood, by Elvira Goettsch,* A.B., M.D., *and John D. Lyttle,* A.B., M.D. *Philadelphia and London: W. B. Saunders Company.* 1951. 1113 pp. with 543 figures. $18.

Reviewed by ROBERT R. BERNEIKE

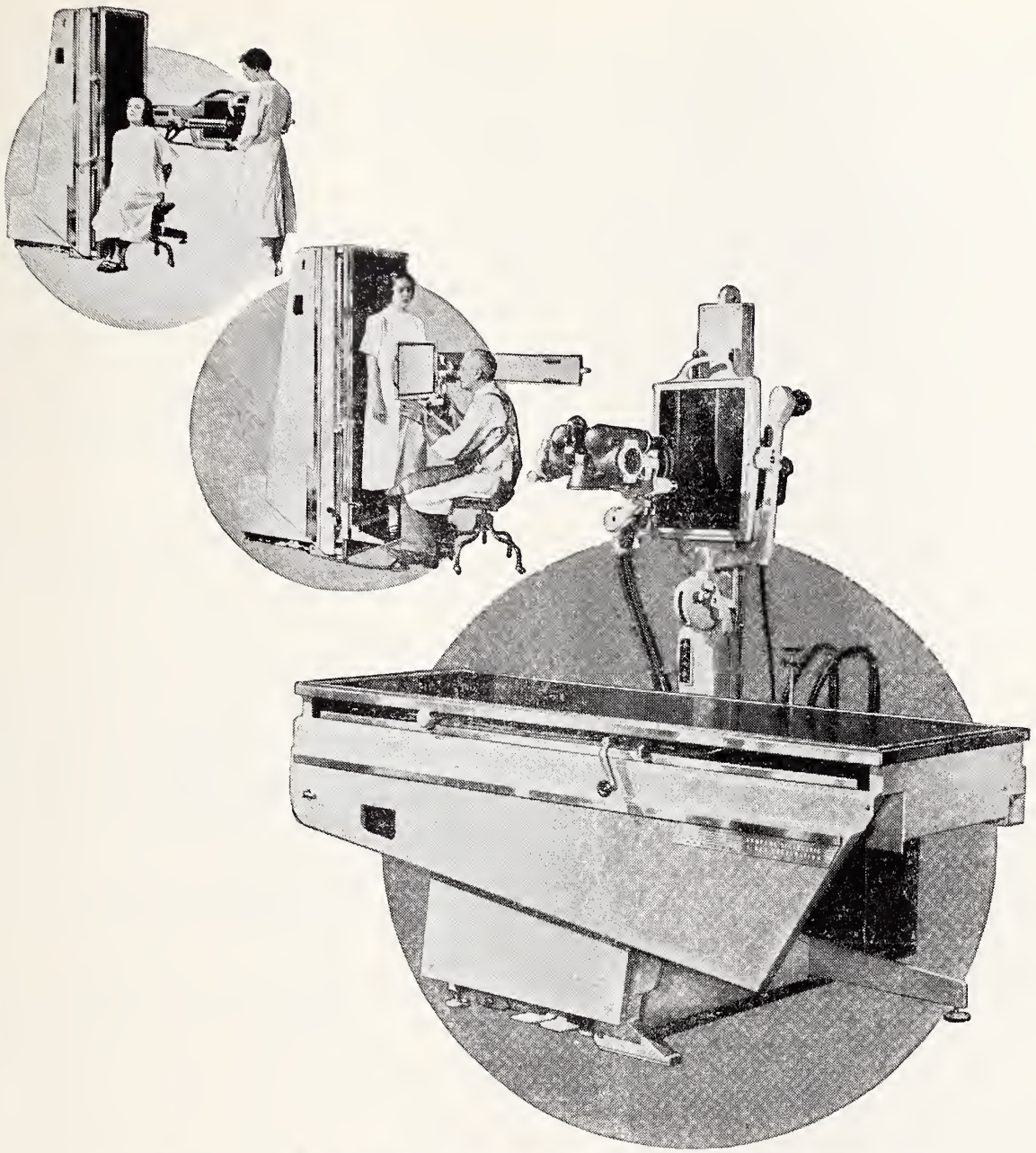
This well written and carefully organized urological text is a worthy monument to the works of Dr. Meredith

"COLLOID BATHS *constitute an essential part of external treatment for many acute and chronic dermatoses*" . . .*

AVEENO...the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.

*"New Type of Colloid Bath" by Kierland & Ede, Rochester, Minn., A.M.A. Arch. of Derm. & Syph., 63,4,502, Apr., 1951.

E. FOUGERA & CO., INC.
75 VARICK ST., NEW YORK 13, N. Y.
Please send professional samples of AVEENO®.
_____ M.D.
ADDRESS _____
CITY _____ STATE _____



ONE TUBE DOES DOUBLE DUTY IN THIS MAXICON

Versatile is the word for this Maxicon. Capable of a wide range of diagnostic service, it has ample facilities for both radiography and fluoroscopy, horizontally and vertically.

Hand-tilt or motor-driven, the single-tube radiographic and fluoroscopic table is designed for operation with 100 or 200 ma generators. Its table-mounted tube stand makes it compact — ideal for small room.

See your x-ray representative or write X-Ray Department, General Electric Company.

GENERAL ELECTRIC

Direct Factory Branch: **178 South Whitney Street, HARTFORD**

Campbell, whose devotion to the urologic problems of infants and children has made him a pioneer in this important branch of surgery. Much of the material in this book is applicable to general urology, but it is all presented with a view to special pediatric implications.

The chapters on endocrinology and on neuromuscular disorders are particularly valuable since similar material is not elsewhere available under one cover in such detail. The section on nephritis and allied diseases by Drs. Goettsch and Lyttle is unique in urological texts and deserve special praise. It is amazingly concise and comprehensive.

Throughout the book divergent views are fairly presented, but the authors are not reluctant to take a position which the reader can recognize, viz., in favor of preoperative irradiation of most Wilms' tumors and early repair of hypospadias, both still controversial subjects.

The classification of renal cysts is incomplete, confusing multilocular cysts with unilateral multicystic kidney disease. The struggle with indications and contraindications for various antibiotics for urinary infection comes to an impasse, as it must, since one cannot specify a certain drug for a certain organism without considering variations in strain sensitivity. In general the discussion of urinary infections is one of the best published anywhere and includes the modern concepts of diagnosis and treatment.

The bibliography is comprehensive and amazingly up to date, and is thus one of the most valuable features of the book. The illustrations and printing are excellent.

This book is highly recommended for any collection of medical literature, and particularly to those interested in the practice of urology.

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY. By Isadore Meschan, M.A., M.D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine. With the assistance of: *R. M. F. Farrer-Meschan*, M.B., B.S., (Melbourne, Australia). *Philadelphia and London: W. B. Saunders Company*. 1951. 593 pp. 1,044 illustrations on 362 figures. $15.

Reviewed by Louis Bernstein

Dr. Meschan's volume on normal radiographic anatomy fills a large gap in the realm of teaching radiographic literature. In his preface the author outlines the scope of this treatise: namely, to correlate anatomy studied in the dissecting room with anatomy in vivo; second, to present a basic knowledge of normal radiographic anatomy and its minor variations to students of radiology and clinical medicine; and third, to prepare a guide and reference for the general practitioners for their everyday problems and for more intelligent consultation with the roentgenologist.

The first chapter presents a brief history of radiology and then, in concise manner, discusses physics and chemistry of roentgenology. Extensive and complicated mathematics are studiously avoided, but rather, fundamental concepts and facts are stressed. Throughout this chapter diagrams are employed to illustrate the working parts of an x-ray tube, circuit, Potter Bucky diaphragm, etc., in order to present a graphic image of the descriptive text.

The second chapter presents a brief survey of the embryology of bone and correlates the microscopic findings with the roentgen picture. A chart is included recording the ages at which ossification centers appear in the upper and lower extremities. This table is invaluable to the pediatrician and radiologist in the study of normal and abnormal epiphyseal development.

Throughout the book excellent reproductions of standard films are employed in conjunction with detailed line drawings and anatomical plates illustrating the parts visualized on the films. Radiographic technic and positioning of the patient is amply described. The value of the volume is enhanced because of brevity and scope without sacrifice of simplicity and conciseness.

This book is to be recommended without reservation for the student in radiology and those interested in roentgen diagnosis.

SURGICAL PRACTICE OF THE LAHEY CLINIC. By members of the staff of Lahey Clinic, Boston. Philadelphia: W. B. Saunders Company. 1951. 784 illustrations.

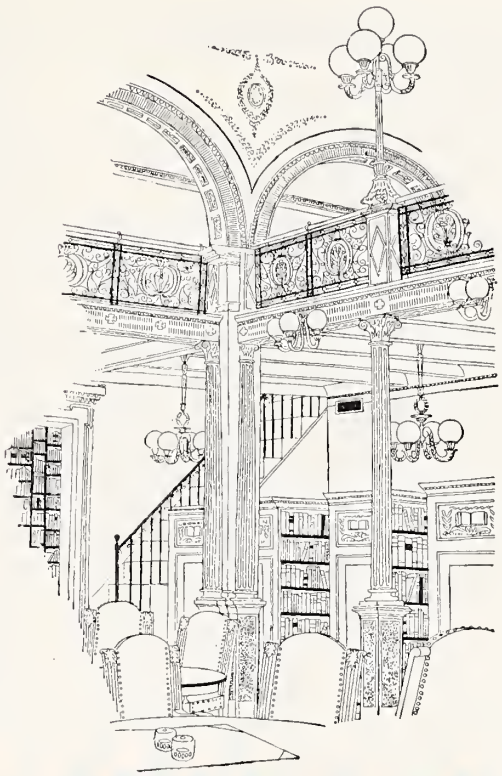
Reviewed by Irving Waltman

This book presents the concepts and methods which have crystallized from a voluminous surgical practice and have become the basis for standardization in surgical management and operative technique at the Lahey Clinic. While such standardization has proved of great value for the successful and efficient operation of a large clinic and has had obvious teaching advantages, it is evident that numerous features might be opened for debate. This does not, however, detract from the usefulness of such a volume, for here are concepts which work and here are excellent detailed descriptions of operative techniques which provide guidance for systematic and anatomical surgery.

The book is a compilation of numerous articles covering general surgery and selected phases of orthopedic surgery, neurosurgery, and anesthesia. Most of the articles have previously appeared in various surgical journals during the past few years and will be familiar to those who know the surgical literature. They are written with directness and clarity which make them easy to digest with a minimum of effort. The descriptions of thyroid, biliary tract, and pancreatic surgery merit special commendation.

Although the volume is devoted primarily to operating room technique, there is considerable emphasis on differential diagnosis and anesthesia as well as pre- and postoperative care. There are also very complete follow-up reports to illustrate the results of the Lahey Clinic methods and afford a basis for comparison with other procedures.

There is a tremendous wealth of practical information packed into this volume. The articles are generously illustrated, well outlined, and have excellent summaries for quick appraisal. This book is undoubtedly destined to be even more popular than its parent volume published just ten years ago and will be of especial value to those attempting to organize their surgical thoughts and standardize their surgical procedures.



from

among all

antibiotics

Pediatricians

often choose

AUREOMYCIN

Hydrochloride Crystalline

because . . . Aureomycin may be given by the oral, or in an emergency by the intravenous, route. Aureomycin readily and rapidly diffuses into all the tissues and fluids of the body.

Aureomycin in divided small dosage has given serum levels comparable with those following one large dose.

Aureomycin is clinically effective in the control of infections of bacterial, rickettsial, and large viral origin.

Aureomycin has been reported to be effective against susceptible organisms in: Bronchiolitis • Bronchitis • Colitis • Epidemic Diarrhea • Childhood Genitourinary Infections • Laryngotracheobronchitis • Secondary Infections following Measles • Mucoviscidosis (pancreatic fibrosis) • Neonatal Infection • Otitis Media • Mastoiditis • Pertussis Pneumonia • Scarlet Fever • Secondary Invasion following Varicella

Throughout the world, as in the United States, aureomycin is recognized as a broad spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

Wanted Experienced Laboratory Technician, registered, for modern 200 bed hospital. Write Box No. 550, Bristol, Connecticut. Salary $300.

Approved interneships (rotating), and residencies in medicine and obstetrics-gynecology; and surgical residency approved only for training in preparation of surgical specialties; for July 1, 1952 or earlier; typical general hospital, modern, well-equipped; wide diversification of diseases; average patient census around 185; plenty of work; good recreational facilities, especially marine. Full-time radiologist, pathologist and anesthesiologist. Stipend for internes $1,200 per year and for residents $1,500-$1,800 per year, plus uniforms and maintenance. Class A medical school graduates only. The Lawrence and Memorial Associated Hospitals, New London, Conn.

PHYSICAL MEDICINE AND REHABILITATION FOR THE CLINICIAN. Edited by Frank H. Krusen, M.D. *Philadelphia: W. B. Saunders Company.* 1951. 371 pp.

Reviewed by JOHN C. ALLEN

This book fills a needed position in the medical writings concerning physical medicine and rehabilitation. It is edited by Frank H. Krusen, M.D., a recognized authority in the field and is contributed to by twenty-four other writers essentially of the male group. There are seven contributors outside of this group, including Howard A. Rusk, M.D. and Arthur L. Watkins, M.D. The book is written in four sections covering therapeutic application and diagnostic application of physical agents and procedures together with one section on the clinical aspects of physical medicine and rehabilitation. A fourth section, which is extremely well done, deals with fundamentals of anatomy, therapeutic exercise, and physiology as related to physical medicine and rehabilitation. This section would be of specific assistance to practically every practicing physician regardless of the specialty which he may be in. The final chapter in this section deals with the physiological effects of bed rest and immobilization and summarizes these affects as determined during the past six years. Generally, the book has much to recommend it for placement on lists of required reading.



TEETHING IS EASIER

When you prescribe

DENTOCAIN TEETHING LOTION

FORMULA— Alcohol 70%
Benzocaine 10%
Chloroform, 4 mins. per fluidounce.



Easier on the Baby . . .

DENTOCAIN TEETHING LOTION makes it easier to go through the troublesome teething period. A small amount, applied with gentle massage, brings quick, soothing relief to irritated and inflamed gum tissue, aids in getting infant back to sleep.

Easier on the Mother . . .

By providing more comfort and extra sleep for the baby, DENTOCAIN TEETHING LOTION grants the mother greater peace of mind and several additional hours of necessary rest.

DENTOCAIN has also been useful in providing temporary relief for pain of adult toothache.

Dentocain Co., Hartford, Conn., U.S.A.

Available on prescription only.
Professional samples and descriptive literature sent on request.

Table of Contents : April 1952

The Heritage of Hartford Medicine — Stanley B. Weld, M.D., Hartford 241

Hypersplenism in Pregnancy
Harry Krochmal, M.D., and Max Caplan, M.D., Meriden 248

Conduction Deafness in Children — Paul B. MacCready, M.D., New Haven 252

The Role of Urea-Splitting Bacteria in Urolithiasis: Description of a Simplified Urea-Agar Medium for Their Detection
Fred C. Collier, M.D., Alfred Reich, B.S., and John W. King, M.D., Cleveland, Ohio 257

Osteochondromatosis of the Hip Joint — Walter A. Dalmain, M.D., Bristol 258

The Structure of Fee Tables in Medical Service Insurance
William H. Horton, M.D., Windsor 260

The Middle Man in Physician-Hospital Relations
Leland S. McKittrick, M.D., Brookline, Massachusetts 263

EDITORIALS

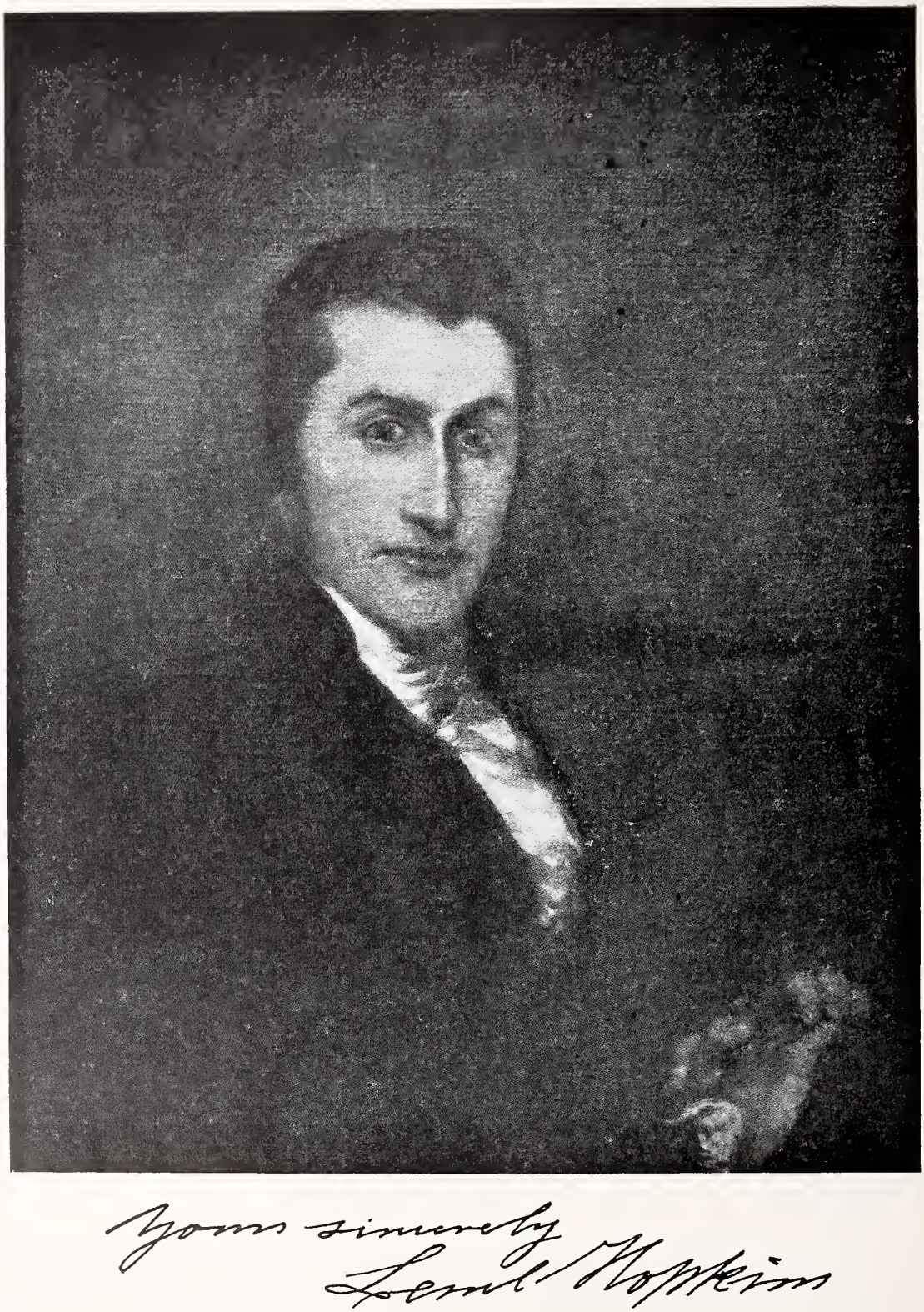
Cancer Control Month 272
Group Catastrophic Illness Insurance 272
A United Profession 273
The Art Exhibit 274
The Ill Effects of Immobilization 274
Something to Vote About 275
More About the National Health Service 275

DEPARTMENTS

Progress in Clinical Medicine
Industrial Medicine as a Legitimate Field for the General Practitioner
John F. Kilgus, Jr., M.D. 278
The President's Page 281
The Secretary's Office 282
Public Relations 285
News From Washington 288
Military Affairs 294
From Our Exchanges 295
Woman's Auxiliary 298
Our Neighbors 304
News From County Associations 304
News From Yale University School of Medicine 304
New Books in Review 306

MISCELLANEOUS

Program—160th Annual Meeting 229
Programs—Annual County Association Meetings 269
The Doctor's Office 293
The Purposes and Functions of Voluntary Health Agencies
Allan J. Ryan, M.D., Meriden 276
Special Notices 300



Photograph of a portrait of Dr. Lemuel Hopkins. The original portrait was painted by John Trumbull in 1793. The copy, from which this photograph was made, was painted by Trumbull in 1825 for Samuel Miles Hopkins

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI APRIL, 1952 No. 4

160th ANNUAL MEETING
of the
Connecticut State Medical Society

BULKELEY HIGH SCHOOL, HARTFORD

April 29, 30, and May 1, 1952

PROGRAM COMMITTEE

JOHN C. LEONARD, *Hartford, Chairman*
STEVENS J. MARTIN, *Hartford*
JOHN F. NOLAN, *Bridgeport*

LOCAL COMMITTEE ON ARRANGEMENTS

JAMES R. CULLEN, *Hartford*, Chairman

JOHN F. BEAKEY, *Hartford* THOMAS M. FEENEY, *Hartford* CHARLES E. JACOBSON, JR., *Hartford*
W. HOLBROOK LOWELL, JR., *Hartford* MICHAEL S. ZEMAN, *Hartford*

PROGRAM

Tuesday, April 29

ANNUAL MEETING OF THE HOUSE OF DELEGATES

BRAE RAFFERTY, *presiding*

10:00 CALL TO ORDER
BUSINESS SESSION

1:00 Luncheon for officers, members of the House and guests

2:00 Resumption of business

7:00 ANNUAL DINNER OF THE COUNCIL—The Council will hold its annual dinner for the Program Committee, the Local Committee on Arrangements, and guests at the Hartford Times Tower, Talcott Mountain, Avon

Wednesday, April 30

GENERAL PROGRAM

Auditorium of the High School

Brae Rafferty, *presiding*

9:00 Registration

9:15 Motion Picture

9:45 Call to Order
Address of Welcome—President of the Hartford County Medical Association

10:00 The Prevention and Treatment of Diarrhea in Infants
Stuart S. Stevenson, *Research Professor of Pediatrics, University of Pittsburgh School of Medicine*

10:30 Current Problems in Antibiotic Therapy
Perrin H. Long, *Professor of Medicine, State University Medical Center at New York City*

11:00 Intermission to visit the technical exhibits

11:15 Coronary Heart Disease as a Problem in General Practice
Robert L. Levy, *Professor of Clinical Medicine, Columbia College of Physicians and Surgeons*

11:45 Modern Concepts of Hepatic Cirrhosis
John G. Mateer, *Physician-in-Chief, Henry Ford Hospital, Detroit, Mich.*

12:30 Intermission to visit the technical exhibits

1:00 Luncheon, Cafeteria of the High School

2:00 Symposium on Indispensable Therapeutics
John C. Leonard, *Hartford, presiding*
Robert L. Levy, *New York*
Perrin H. Long, *New York*
John G. Mateer, *Detroit*
Stuart S. Stevenson, *Pittsburgh*

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

Hartford Golf Club

President: Mrs. F. Erwin Tracy Secretary: Mrs. Harry C. Knight

11:00 Registration and Social Hour

12:00 Luncheon

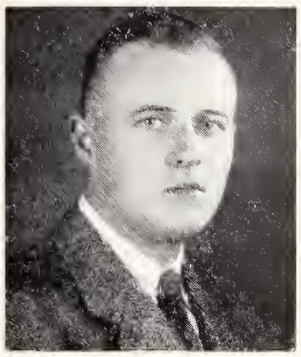
1:00 The Length of Life
Perrin H. Long, *Professor of Medicine, State University Medical Center at New York City*

1:45 Business Meeting

3:00 The Artist at Work
Presentation by a member artist

4:00 Adjournment

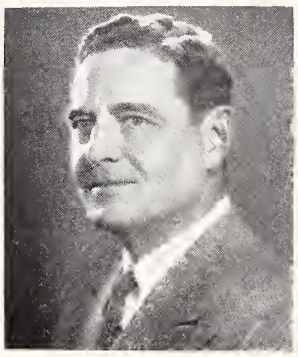
Members of the Auxiliary are urged to attend the Art Exhibit at the Bulkeley High School, 470 Maple Avenue, Hartford



Stuart S. Stevenson, Pittsburgh, Pennsylvania; Special Consultant, Office of Surgeon General, 1944-46; Private Practice (pediatrics), Fairfield, Conn., 1945-46; Assistant Physician, Children's and Infant's Hospitals, Boston, 1946-47; Assistant Professor of Child Health, Harvard University, 1947-49; Associate Physician, Children's and Infant's Hospitals, Boston, 1947-49; Research Professor of Pediatrics, University of Pittsburgh School of Medicine, 1949-; Senior Pediatrician, Children's Hospital of Pittsburgh, 1949-.



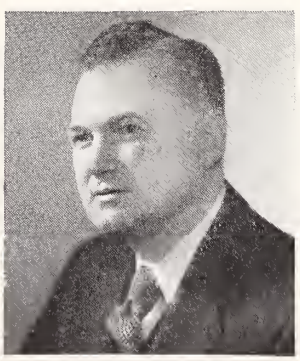
Perrin H. Long, New York City; Rockefeller Institute, 1927-29; Associate Professor of Medicine, Johns Hopkins Medical School, 1937-40; Professor of Preventive Medicine, Johns Hopkins Medical School, 1940-51; Professor of Medicine and Executive Officer, Department of Medicine, College of Medicine, State University Medical Center at New York, 1951-.



Robert L. Levy, New York City; Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University; Attending Physician, Presbyterian Hospital, New York, N. Y.



John G. Mateer, Detroit, Michigan; Physician in charge of Division of Gastroenterology, Henry Ford Hospital, Detroit, 1920-; Physician in chief, Henry Ford Hospital, Detroit, 1952-; President, American Gastroenterological Association, 1950-51.



William Joseph Mulligan, Boston, Masachusetts; Assistant Obstetrician, Boston Lying-in Hospital, 1947-; Associate Surgeon, Free Hospital for Women, 1947-; Assistant in Obstetrics and Assistant in Gynecology, Harvard Medical School.

SECTION ON DERMATOLOGY AND SYPHILOLOGY

3:30 Room 135

Chairman: Albert Rubin Secretary: Carter L. Marshall

Dermatitis of the Hands

Frank C. Combes, *Professor of Dermatology, New York University-Bellevue Medical Center College of Medicine, New York City*

SECTION ON GASTROENTEROLOGY

1:00 Cafeteria

Chairman: Samuel D. Kushlan Secretary: Benjamin V. White

Business Meeting

The Section will meet informally at lunch in the school cafeteria, and attend the meeting of the American Board Surgeons on Thursday, May 1

SECTION ON RADIOLOGY

3:30 Room 169

President: Wendell C. Hall Secretary: Fred Zaff

Hydrocephalus

Edward B. D. Neuhauser, *Roentgenologist, Infants and Childrens Hospital, Boston; Instructor Roentgenology, Harvard Medical School*

CONNECTICUT ALLERGY SOCIETY

3:00 Room 303

President: Barnett P. Freedman Secretary: Paul Winer

Recent Advances in the Management of Bronchial Asthma

Francis C. Lowell, *Associate Professor of Medicine, Boston University School of Medicine; Physician-in-charge of Allergy Clinic, Massachusetts Memorial Hospital*

The speaker will be preceded by a color motion picture entitled, "Allergy"

CONNECTICUT DIABETES ASSOCIATION

3:30 Room 134

President: Burdette J. Buck Secretary: James C. Hart

The Diabetes Problem—Certain Aspects of Diagnosis and Patient Management

Hugh L. C. Wilkerson, *Chief, Diabetes Section, U. S. Public Health Service, Boston*

CONNECTICUT ASSOCIATION OF MEDICAL RECORD LIBRARIANS

2:30 Room 145

President: Miss Mary Ross Page Secretary: Miss Janet Davis

Personnel Relations

Miss Mabel G. Martin, *Personnel Director, Grace-New Haven Hospital, New Haven Unit*

CONNECTICUT BRANCH, AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS

2:00 Room 107

President: Mrs. Allene Jackson Secretary: Miss Josephine Vignone

Medical-Social Management of an Adolescent Boy With Epilepsy

Moderator: Miss Eckka Gordon, *Director of Social Service, Grace-New Haven Hospital*

Panel:

Philip R. Partington, *Clinic Physician in charge of Out-Patient Department, Hartford Hospital*

Mrs. Deenah S. Stolman, *Director of Social Service, Hartford Hospital*

Miss Dorothy E. Barrett, *Medical Social Worker, Hartford Hospital*

CONNECTICUT SOCIETY FOR PSYCHIATRY AND NEUROLOGY

3:30 Room 144

President: Helen R. Gilmore Secretary: Harold S. Wright

Psychophysiological Basis for Therapy of Organic Disease

Sydney G. Margolin, *Associate Psychiatrist and Director of In-Patient Psychiatric Service, Mt Sinai Hospital, New York*

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

3:30 Room 116

Chairman: Louis P. Hastings Secretary: Robert Tennant

Business Meeting

HEZEKIAH BEARDSLEY PEDIATRIC CLUB

3:30 Room 236

President: Joseph L. Hetzel Secretary: James H. Root, Jr.

Mental Health in Childhood

Stuart S. Stevenson, *Research Professor of Pediatrics, University of Pittsburgh School of Medicine; Senior Pediatrician, Children's Hospital of Pittsburgh*

Annual Dinner of the Society

Hartford Club

46 Prospect Street, Hartford

7:00

PROGRAM

The President, Brae Rafferty, *presiding*

Introduction of newly elected officers

Presentation of guests and delegates from state medical societies

Fifty Year Membership Awards

Millard F. Allen, *New Haven*

William T. Bronson, *Danbury*

Patrick J. Dwyer, *Waterbury*

Charles O. Purinton, *New Hartford*

Speaker: The Honorable John Lodge, *Governor of the State of Connecticut*

Entertainment—Musical Program

Reservation cards for the Annual Dinner will be included with the program of the meeting which will be distributed to all members—wives of members are invited to attend

Thursday, May 1

GENERAL PROGRAM

Auditorium of the High School

Joseph H. Howard, *presiding*

9:15 Registration

9:30 Motion Picture

10:00 Common Defects in Reproductive Physiology
William J. Mulligan, *Assistant Obstetrician and Gynecologist, Harvard Medical School*

10:30 The General Practitioner as a Urologist
Elmer Hess, *Chief Urologist, St. Vincent's Hospital and Hamot Hospital, Erie, Pennsylvania; President, American Urological Association*

11:00 Intermission to visit the technical exhibits

11:15 Thromboembolism
Alton S. Ochsner, *William Henderson Professor of Surgery, Tulane University, New Orleans*

11:45 The Physician Looks at Murder
Richard Ford, *Medical Examiner for Suffolk County, Assistant Professor of Legal Medicine, Harvard Medical School*

12:30 Intermission to visit the technical exhibits

1:00 Luncheon, Cafeteria of the High School

2:00 Symposium on Peptic Ulcer
Arranged by The Connecticut Society of American Board Surgeons
President: Welles A. Standish Secretary: Courtney C. Bishop

Physiology, Etiology and Application of Vagus Nerve Interruption
Cranston W. Holman, *Associate Professor of Clinical Surgery, Cornell Medical College; Associate Attending Surgeon, New York Hospital*

Medical Aspects of Peptic Ulcer
Samuel D. Kushlan, *Associate Clinical Professor, Yale Medical School; Attending Physician, Grace-New Haven Community Hospital*

Acute Massive Hemorrhage
John D. Stewart, *Professor of Surgery, University of Buffalo; Surgeon-in-Chief, Edward J. Meyer Memorial Hospital*

General Surgical Considerations
Leland S. McKittrick, *Clinical Professor of Surgery, Harvard Medical School; Visiting Surgeon, Massachusetts General Hospital*

4:00 Intermission

4:15 Round Table Discussion
Welles A. Standish, *Hartford, presiding*
Cranston W. Holman, *New York*
Samuel D. Kushlan, *New Haven*
John D. Stewart, *Buffalo*
Leland S. McKittrick, *Boston*



Elmer Hess, Erie, Pennsylvania; Chief Urological Department and Assistant Chief of Staff, St. Vincent's Hospital, Erie; Chief, Urological Department, Hamot Hospital, Erie; Chairman, Committee on Extension of Hospitals and Other Facilities, AMA Council on Medical Service; President, Dr. Hess Urological Foundation.



Richard Ford, Boston, Massachusetts; Research Fellow in Legal Medicine and Research Fellow in Pathology, Harvard Medical School, 1945-; Lecturer on Medical Jurisprudence, Tufts Medical School, 1950-, and Yale University School of Medicine, 1949-; Medical Examiner, Suffolk County, 1950-; Acting Head, Department of Legal Medicine, and Assistant Professor of Legal Medicine, Harvard Medical School, 1949-.



Alton Ochsner, New Orleans, Louisiana; William Henderson Professor of Surgery, Tulane University, 1938-; Director of General Surgery at Ochsner Clinic and Foundation Hospital; Senior Visiting Surgeon and Surgeon in chief, Tulane Surgical Service at Charity Hospital, New Orleans; President, American College of Surgeons; Recipient of *Times-Picaynne* Loving Cup as outstanding citizen of New Orleans, 1945.



Henry L. Birge, Hartford, Connecticut; Associate Ophthalmologist, Hartford Hospital, Hartford; Assistant Clinical Professor of Ophthalmology, Yale University School of Medicine, New Haven; Consulting Ophthmalogist to several hospitals in Connecticut.



Marion B. Sulzberger, New York City; Private Practice of Dermatology, 1935-47; Professor of Clinical Dermatology and Syphilology, N. Y. Postgraduate Medical School, 1947-48; Executive Officer, Department of Dermatology, N. Y. University Post-Graduate Medical School and University Hospital, 1947-; Professor of Dermatology and Syphilology, N. Y. University Post-Graduate Medical School, N. Y. University-Bellevue Medical Center, 1948-; Director, Service of Dermatology and Syphilology, Skin and Cancer Unit and University Hospital, N. Y. University-Bellevue Medical Center, 1949-.

MEETINGS OF SECTIONS OF THE SOCIETY AND GUEST ORGANIZATIONS

JOINT MEETING

2:00 Room 169

CONNECTICUT CHAPTER–AMERICAN ACADEMY OF GENERAL PRACTICE

President: Peter J. Scafarello Secretary: Mario P. Rocco

CONNECTICUT RHEUMATISM ASSOCIATION

President: LeMoyne C. Kelly Secretary: Albert A. LaPlume

Peter J. Scafarello, *Hartford, presiding*

2:00 Prevention of Blindness From Glaucoma Through Closer Cooperation Between the General Practitioner and the Eye Physician

Henry Birge, *Associate Ophthalmologist at Hartford Hospital; Assistant Clinical Professor at Yale Medical School*

Special Colored Sound Film Entitled: "What the General Practitioner Should Know About Glaucoma"—Presented by the National Society for the Prevention of Blindness

Myles Standish, *Hartford, presiding*

2:50 Possible Relationship Between Skin Diseases and the Emotions

Marion B. Sulberger, *Professor and Chairman of Department of Dermatology and Syphilology, New York University Postgraduate Medical School*

Edward H. Crosby, *Hartford, presiding*

3:40 Backache and the Backache Tetrad

John Cobb, *Professor of Orthopedics at the Polyclinic Medical School and Hospital*

John C. Leonard, *Hartford, presiding*

4:30 The Physiological Effects of Placebo Administration

Stewart Wolf, *Associate Professor of Medicine, Cornell University Medical School, New York*

6:30 Social Hour, Hartford Club, 46 Prospect Street, Hartford

7:00 Dinner–Hartford Club

Speaker: Wingate Johnson, *Winston-Salem, North Carolina, Chairman of the Section on General Practice of Medicine of the American Medical Association*

SECTION ON ANESTHESIA

3:30 Room 336

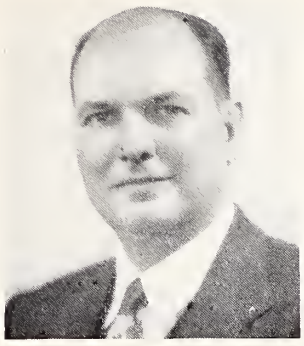
President: Charles M. Barbour Secretary: Leopold M. Trifari

The Physiology of Electrophrenic Respiration

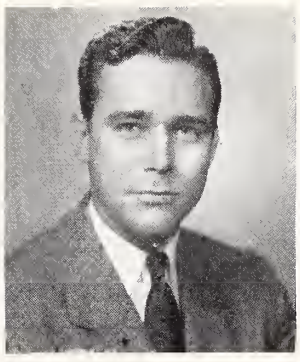
Stanley J. Sarnoff, *Associate Professor of Physiology, Harvard University School of Public Health*

Electroencephalography in Clinical Anesthesia

Raymond F. Courtin, *Section on Anesthesiology, Mayo Clinic*



John Robert Cobb, New York City; Professor of Orthopedics, Polyclinic Medical School and Hospital, New York City; Consulting Orthopedist, St. Charles Hospital, New York City; Former Teaching Fellow, Orthopedic-Surgical Hospital for Ruptured and Crippled.



Stewart Wolf, New York City; Associate Professor of Medicine, Cornell University Medical School; Clinical Associate Neuropsychiatrist, Bellevue Hospital; Associate Attending Physician, New York Hospital; Physician in charge, Psychosomatic Clinic, Department of Medicine, Cornell-New York Hospital.



Wingate M. Johnson, Winston-Salem, North Carolina; Professor of Clinical Medicine and Chief of Diagnostic Clinic, Bowman Gray School of Medicine, Wake Forest College; Editor, *North Carolina Medical Journal*.



Bulkeley High School

EYE, EAR, NOSE, AND THROAT SECTION

3:30 Room 222

President: Joseph F. Watts Secretary: Max Alpert

Modern Treatment of the Chronic Ear

Philip Meltzer, *Professor of Otolaryngology; Tufts Medical School*

Modern Trends in Ophthalmic Surgery

Joseph Wadsworth, *Instructor of Ophthalmology, College of Physicians and Surgeons*

SECTION ON OBSTETRICS AND GYNECOLOGY

3:30 Room 333

Chairman: Harry F. Pennington Secretary: Orvan W. Hess

Ovarian Dysfunction

William Mulligan, *Assistant Obstetrician and Gynecologist, Harvard Medical School*

SECTION ON PHYSICAL MEDICINE

3:30 Room 236

President: Karl B. Bretzfelder Secretary: John C. Allen

The United Mine Workers' Rehabilitation Program

Mr. Kenneth E. Pohlmann, *Director of Rehabilitation, United Mine Workers Welfare and Retirement Fund, Washington, D. C.*

SECTION ON PROCTOLOGY

3:30 Room 337

President: Joseph C. Quatrano Secretary: Frederick S. Ellison

Roentgen Evaluation of Rectosigmoid Lesions

Gilbert W. Heublein, *Associate Radiologist, Hartford Hospital*

CONNECTICUT CHAPTER–AMERICAN PHYSICAL THERAPY ASSOCIATION

3:30 Room 145

President: Mr. Herbert H. Jones Secretary: Miss Victoria Preitner

Follow Up Home Care

Miss Mary Macdonald, *Physical Therapy Supervisor, Visiting Nurse Association, Boston*

CONNECTICUT OCCUPATIONAL THERAPY ASSOCIATION

10:00 Room 236

President: Miss Eleanor Kille Secretary: Miss June Sokolov

10:00 Business Meeting

2:00 A Scientist's Views of Functional Music in Occupational Therapy
Mr. A. Flagler Fultz, *Director, Musical Guidance, Boston*

3:30 The Occupational Therapy Association will join the Section on Physical Medicine

JOINT MEETING

3:30 Room 303

ASSOCIATION OF MEDICAL EXAMINERS OF CONNECTICUT

President: Walter Weissenborn Secretary: Samuel B. Rentsch

CONNECTICUT SOCIETY OF PATHOLOGISTS

President: Roy N. Barnett Secretary: John E. Thayer

PANEL DISCUSSION—COLLECTION AND STUDY OF EVIDENCE FROM THE MEDICO-LEGAL AUTOPSY

Richard Ford, *Medical Examiner for Suffolk County; Assistant Professor of Legal Medicine, Harvard Medical School*
Abraham Stolman, PH.D., *Toxicologist for State of Connecticut*
Others to be announced

The Association of Medical Examiners of Connecticut will have a business meeting at 2:00 P. M.

SECTION ON ORTHOPEDICS

7:00 HARTFORD CLUB

Chairman: Maurice F. O'Connell Secretary: George G. Fox

ASEPTIC NECROSIS OF THE HEAD OF THE FEMUR FOLLOWING INJURY

Beckett Howorth, *Associate Visiting Orthopedic Surgeon, Bellevue Hospital, New York; Professor, Orthopedic Surgery, New York University, Bellevue Medical Center*

ANESTHESIA STUDY GROUP

8:00 1943 Broad Street, Hartford

Chairman: Mary Louise White Secretary: Ruth M. Anderson

GROUP DISCUSSION OF ANESTHETIC MORTALITY AND MORBIDITY TO FOLLOW MEETING OF SECTION ON ANESTHESIA

SECTION ON UROLOGY

3:30 Room 114

President: John B. Goetsch Secretary: Samuel A. Robb

Program to be announced

ART EXHIBIT

CONNECTICUT PHYSICIANS' ART ASSOCIATION

Rooms 141-142

EXHIBIT COMMITTEE

Mrs. Nicholas Marinaro, *Cedarcrest, Newington*
Frederick W. Roberts, 158 *Whitney Avenue, New Haven*

Technical Exhibits — 1952 Annual Meeting

Space	*Firm*	*Location*
1	E. L. Washburn & Company, Inc.	New Haven, Conn.
2	Mead Johnson & Company	Evansville, Ind.
3	Burroughs Wellcome & Company (U. S. A.), Inc.	Tuckahoe, N. Y.
4	Denver Chemical Mfg. Company, Inc.	New York, N. Y.
5	Pet Milk Company	St. Louis, Mo.
6 and 7	Chesco—Connecticut Hospital Equipment & Supply Company (Division of G. Fox & Co.)	Hartford, Conn.
8	W. B. Saunders Company	Philadelphia, Pa.
9	Vanpelt & Brown, Inc.	Richmond, Va.
10	G. D. Searle & Company	Chicago, Ill.
11	C. B. Fleet Company, Inc.	Lynchburg, Va.
12	The Baker Laboratories, Inc.	Cleveland, Ohio
13	Lederle Laboratories Division, American Cyanamid Company	New York, N. Y.
14	U. S. Vitamin Corporation	New York, N. Y.
15 and 16	Surgeons & Physicians Supply Company	Boston, Mass.
17	Philip Morris & Company, Ltd., Inc.	New York, N. Y.
18 and 19	American Surgical Supply & Equipment Company	Bridgeport, Conn.
20 and 21	Professional Equipment Company	New Haven, Conn.
22	A. H. Robins Company, Inc.	Richmond, Va.
23	Ames Company, Inc.	Elkhart, Ind.
24	Doho Chemical Corporation	New York, N. Y.
25	Ayerst, McKenna & Harrison, Ltd.	New York, N. Y.
26	Spencer, Incorporated	New Haven, Conn.
27	Sandoz Chemical Works, Inc., Pharmaceutical Division	New York, N. Y.
28	Ciba Pharmaceutical Products, Inc.	Summit, N. J.
29	Wm. P. Poythress & Company, Inc.	Richmond, Va.
30	Smith, Kline & French Laboratories	Philadelphia, Pa.
31	E. F. Mahady Company	Boston, Mass.
32	Winthrop-Stearns, Inc.	New York, N. Y.
33	E. R. Squibb & Sons	New York, N. Y.
34	The Harrower Laboratory, Inc.	Jersey City, N. J.
35	Parke, Davis & Company	Detroit, Mich.
36 and 37	The D. G. Stoughton Company	Hartford, Conn.
38	Eli Lilly & Company	Indianapolis, Ind.
39	Vaisey-Bristol Shoe Company, Inc.	Rochester, N. Y.
40	Coca-Cola	Atlanta, Ga.
	EXHIBITS IN LOBBY	
41	Desitin Chemical Company	Providence, R. I.
42	Nepera Chemical Company, Inc.	Yonkers, N. Y.
43	Varick Pharmacal Company, Inc. (Division of E. Fougera & Company, Inc.)	New York, N. Y.
44	Chas. Pfizer & Company, Inc.	Brooklyn, N. Y.
45	H. P. Hood & Sons	Boston, Mass.
46	Camel Cigarettes	New York, N. Y.
47	Pepperidge Farm, Inc.	Norwalk, Conn.
48	Saratoga Springs Authority	Saratoga Springs, N. Y.
49	H. J. Heinz Company	Pittsburgh, Pa.
50	Brewer & Company, Inc.	Worcester, Mass.

* * * * *

American Medical Education Foundation
Committee on Public Relations
Connecticut Cancer Society
Connecticut Dairy and Food Council
Connecticut Hospital Association
Connecticut Hospital Service
Connecticut Medical Service
Connecticut State Department of Health
National Foundation for Infantile Paralysis
Today's Health
Veterans Administration

THE HERITAGE OF HARTFORD MEDICINE

Stanley B. Weld, m.d., *Hartford*

Medical practice in Hartford in retrospect is primarily a story of individuals and institutions. The physicians are remembered for their idiosyncrasies as well as for their accomplishments, the institutions for their contribution to society. It may be difficult for us to visualize the days when of an afternoon the road from Hartford to Wethersfield was hub deep in mud, or the days when to cross the Connecticut River one must use a ferry, or those dreamy spring days when Samuel Clemens found delight in contemplating the bubbling brook which ran through his Nook Farm. Even the more recent days of the horse-car, the blizzard of '88, and the horse races at Charter Oak Park reached by means of the open, double running board trolleys may produce a wave of nostalgia in the Harftord-born physician and perhaps to a lesser degree in one who years ago adopted Hartford as his home.

It is a far cry from the days of Thomas Lord, that first doctor of medicine to be granted a license to practice by the General Court, to the life of the 20th century physician in this Capitol City. In those days, a few years after Hartford was settled, medical training was unknown and the colony was fortunate in having this young man from England who was interested in the health of his fellow colonists, while he was eaking out a living by teaching school. Another early arrival, Jasper Gunn, rode down from Roxbury, Massachusetts and took up the "practise of phissicke," because of which he was excused "from training, watching and warding." His sidelines were farming, storekeeping and operating a sawmill.

There were other medical stalwarts in those early days in Hartford, outstanding among them John Winthrop, Jr., who had the honor of attending most of the prominent citizens of the colonies in this vicinity. A Scotchman by the name of Norman Morrison arrived in the colonies in 1733 and was the first to separate medicine from pharmacy and to encourage an independent apothecary in Hartford. The two professions were not immediately divorced, witnessed by the arrival in Hartford in the mid 18th century of William Jepson from Boston, an apothecary who later was instructed in physic and surgery. Jepson joined up with Dr. Sylvester Gardner in establishing an apothecary shop at the sign of the Unicorn and Mortar on Queen Street. Dr. Gardner, a Tory, was obliged to flee to Nova Scotia, and the partnership ended in bankruptcy for Jepson. Then there was that nature loving, Harvard College graduate, Thomas Langrell, who in 1757 on a quest for rose leaves while crossing the Connecticut River in a rowboat was drowned trying to save his companion accidentally thrown into the water.

The outstanding personality among the physicians of Hartford in the latter part of the 18th century without any doubt was Lemuel Hopkins. Tall, lean, stooping, eccentric, with uncouth features, this graduate of Yale attained the highest reputation as a physician in the entire State of Connecticut. Combining a rare interest in his patients which at times made him oblivious to time, food and surroundings, with an unusual poetic wit of an humorist and satirist, this gentleman has left an indelible impression on medical practice in Hartford and even more on literary satire of that period. Brought up in Salem society, now Naugatuck, a frail youth "troubled with a cough, hoarseness, a pain in the breast, and spitting of blood," given a classical education by his father, a student of medicine under Dr. Jared Potter of Wallingford and Dr. Seth Bird of Litchfield, a volunteer soldier in the Revolutionary Army, Lemuel Hopkins came to Hartford in 1784 and lived there until his death in 1801. To his patients he was the soul of attention, winning their confidence and friendship, occasionally spending all his time with one, even to giving every dose of medicine himself. He received medical students for instruction, inoculated patients against small pox, and acquired a reputation in the treatment of pulmonary tuberculosis. It is said that one patient came all the way from New Orleans to see him. He believed pulmonary tuberculosis was curable if proper treatment was given early and he also attempted to prove that common colds are caused by heat.

In addition to this position of renown as a physician of unusual ability, Dr. Hopkins is remembered as one of the more prominent members of the Hartford Wits. This group met weekly to discuss political and philosophical subjects and comprised a number of remarkable characters led by John Trumbull, the lawyer. Each member of this select group is said to have been an admirer of every other member. Dr. Walter Steiner in his interesting account of the

Hartford Wits lists them as John Trumbull; Timothy Dwight of New Haven, president of Yale College and "a preacher of righteousness;" David Humphreys, soldier and diplomat, a friend of Washington; Joel Barlow, chaplain in the Revolution, newspaper editor, unsuccessful lawyer, man of letters, finally minister to France; Theodore Dwight, newspaper editor, Congressman and secretary of the Hartford Convention; Richard Alsop, absorbed in literature and a polylinguist; and Lemuel Hopkins, general practitioner of medicine, consultant especially in the treatment of tuberculosis, a satirist in his own right. Added to them later were Dr. Elihu H. Smith, a lover of literature and prominent as secretary of the Hartford County Medical Association, and Dr. Mason F. Cogswell, famous as a surgeon, founder of the school for the deaf and dumb, and the first in America to ligate the common carotid artery. Thacher in his biography adds to the Hartford Wits Noah Webster, Rev. Nathan Strong, William Brown and on occasions Zephaniah Swift, Uriah Tracy and Tappan Reeve. Dr. Hopkins' poems were full of sharp, biting wit. One on "The Cancer Quack" is said to have been the means of driving a noted cancer quack out of Hartford. With others of the Hartford Wits he wrote "The Anarchiad," a political satire, "The Echo," a medley of burlesque and satirical pieces, and "The Political Green House," a poem devoted to politics.

Following the death of Lemuel Hopkins, Hartford produced several physicians who individually and collectively have left their imprint on the city and the practice of medicine. In 1819 there lived and practised in this city Mason F. Cogswell, Leonard Bacon, Barwick Bruce, Judah Bliss, Dwell Morgan and John L. Comstock, and to them soon were added George Sumner and Eli Todd. The question of the day medically was, "Are you a bleeder or are you a stimulator?" These ten were all individualists. A story is told of Dr. Bacon, who came to Hartford on horseback from Stoughton, Massachusetts, carrying his wardrobe, his library and his materia medica in his saddle bags. One morning upon meeting Rev. Strong in the market he asked the latter why people called a baked hog's head the minister's face. "For the same reason," replied the minister, "that they call the other end the Bacon."

Then there was Sylvester Wells who with others formed the "aristocratic wing of the democratic party," a member of the convention which framed our present constitution and abrogated the charter of King Charles. In his later years he could be seen standing at his gate at the head of Wells Lane, a tall gaunt figure without a hat, with gray bushy eyebrows, clad in a calico dressing gown and complaining because some of the neighborhood boys had stolen fruit from his trees.

Among these early physicians three stand out, Mason F. Cogswell, Eli Todd and George Sumner. Dr. Cogswell was a charter member of the Connecticut Medical Society, its treasurer for four years, vice-president and later president for ten successive terms. He was prominent as a surgeon and as an accoucheur, and was instrumental in founding in



Eli Todd

1817 the first deaf and dumb institution in the United States, The American Asylum. Eli Todd was responsible for the founding of the Hartford Retreat. The only guides which his committee had for laying plans for the first hospital for the insane in this country were Pinel on Insanity and Tukes' History of the Retreat near York, England. Todd was a detailist, a great conversationalist, and at the same time was modest and unassuming. George Sumner is best known for his devotion to the practice of medicine to which he literally gave his life. An intellectual, Dr. Sumner did not enjoy a very lucrative practice but during his early years in Hartford found most of his patients in the Sinking Fund, on Dutch Point, Albany Road, and near Imlay's Flour Mill. The Sinking Fund was a distillery together with a long brick house "on the north end of Front Street," built by the Hartford clergyman, Rev. Strong, and some of his friends. The company failed



IMLAY'S MILLS ON PARK RIVER
nearly south of railroad station at site of present tool house

and the property was lost. Succeeding Eli Todd, Silas Fuller became superintendent at the Retreat. During his days of practice in Columbia before coming to Hartford he became famous as an avid reader of books, frequently finishing one which he might discover in the home of a patient before taking his leave. He must have been a disorderly superintendent for when Amariah Brigham succeeded him as administrator at the Hartford Retreat he is said to have "introduced order and system." Dr. Brigham was invited to come to Hartford from Greenfield, Massachusetts because the former city was said to be in need of a surgeon and here was a gentleman who had studied in France. He proved an asset to the profession here, writing a book, "The Brain and Nervous System," and contributing extensively to medical journals, newspapers and magazines.

The Beresfords, father and son, made a distinguished pair. Both from British Guiana and both skilled surgeons, in their days in Hartford they were seldom seen on the street except in the company of each other. As these two large, broad shouldered gentlemen entered a patient's room, as though trained in the act, each pulled out his watch and in a single gesture grasped either wrist to count the pulse. Any common chaise was too lightly constructed to carry both at the same time, so they rode in a heavy, four wheeled carriage apparently of English make. Concerning the father, James, it is reported that he "drank his wine like a gentleman, was a devout churchman, and said his prayers upon entering church in the English manner, standing with head bowed and his face in his hat." To the son, Samuel, the Hartford Hospital owes a large debt of gratitude for his surgical assistance over a period of many years. Realizing this, the colored memorial window bearing the name of Samuel B. Beresford, M.D., F.R.C.S., was removed from the old hospital

structure, now destroyed, and placed in the new Hartford Hospital. Dr. Samuel Beresford was one of those characters who makes history. Born in the torrid climate of Dutch Guiana, he never wore flannel undergarments nor any but low shoes. On one of the coldest winter days he is said to have made the journey all the way to Lakeville and return in an open sleigh. In the Hartford Hospital he was so faithful to his ward patients that he often visited them two or even three times a day to the neglect of his private practice. Dr. Gurdon Russell tells the following story about Samuel Beresford. One night quite late the latter's doorbell rang. A little irked by the late caller, the doctor responded with "Why didn't your father send for me before?" Back came the reply on the instant, "Cos' he wasn't sick."

Another character was the remarkable George Benjamin Hawley. To him belongs the credit for



George Sumner

conceiving and carrying out a plan whereby Hartford came into possession of its first general hospital. He had arrived in the city via a devious route from his birthplace in Bridgeport, home in Watertown, school in Goshen, college at Yale, then Yale Medical Department and practice in Charlton, Massachusetts. For four years he was an assistant to Dr. Silas Fuller at the Retreat, then he started up in general practice and married Dr. Fuller's daughter. He was a man of determination, ambitious for success and worked hard to acquire it. For several years a few benevolent people, among them a Dr. Wilson, had maintained in Hartford a "Home for the Sick." Dr. Hawley visualized a real hospital and went to work to secure funds for the same. In 1854, chiefly through his efforts, the Hartford Hospital was incorporated and from then till his death in 1883 it was first in his thoughts. He possessed scant knowledge of hospital structures and management but demonstrated a remarkable acuteness and sound judgment in the construction and maintenance of the hospital. For 28 years he prepared and presented each annual report of the hospital's executive committee. In his later



Samuel B. Beresford

years he attempted to establish an asylum at Walnut Hill for inebriates but this was never accomplished. At his death he was in the midst of securing funds for a home for old people. Hartford owes much to George Hawley.

In 1829 a group of physicians in and around Hartford met and formed the Hopkins Medical Association. According to the preamble of its constitution these gentlemen organized "for the purpose of our own individual improvement in the Science of Medicine, of contributing something for its achievement, and of encouraging and supporting that mutual regard and friendly intercourse among ourselves which ought ever to exist between members of the Medical Profession." The list numbers 29 Fellows, chiefly from Hartford, the outstanding noticeable exception being Richard Warner of Haddam. There were in addition 22 corresponding members who included John R. Watrous of Colchester, Eli Ives of New Haven, L. W. Belden of Springfield, Massachusetts, and Elisha North of

New London. According to the constitution no one holding a professed nostrum or patent could be either a Member or a Fellow and no one living outside the borders of Connecticut could qualify as a Fellow. "Anniversary meetings" and "ordinary meetings" were provided for. Dissertations were read at the meetings, the essayists being selected from the Fellows in turn, two at a time. Refusal to produce carried with it a fine of $1 which became $3 if the essayist had accepted and then reneged at the last minute. In the by-laws was a provision that no vote of thanks be passed for any dissertation read by appointment. Mason F. Cogswell was the first president; Eli Todd, vice-president; William James Barry, recording secretary; George Sumner, corresponding secretary; and Elijah F. Reed, treasurer. The society seems to have prospered for 14 years as evidenced by the recorded minutes now in safe keeping in the library of the Hartford Medical Society. Apparently three papers were read on February 8, 1843, one by Daniel Holt of Glastonbury on pneumonia, one by G. B. Huntley on opium, and a third by William C. Williams on neuralgia or nervous rheumatism. This is the last recorded gathering of this society. Just what happened we can merely conjecture, but three years later, on Thursday, August 27, 1846, a group of Hartford physicians met at the home of Dr. George Sumner and elected Benjamin Rogers chairman and Gurdon Russell clerk. This was the organizational meeting of the Hartford Medical Society. A few days later, on Tuesday, September 15, the same physicians met again, this time at the home of Dr. Dodge because of illness in Dr. Rogers' family. Rules were adopted and the purpose of the Society is thus laid down: "The object of this Society is to maintain the practice of Medicine and Surgery in this City upon a respectable footing; to expose the ignorance and resist the arts of quackery; and to adopt measures for the mutual improvement, pleasant intercourse, and common good of its members." Then followed a number of regulations which might well have been labelled by-laws. These provided for meetings the first and third Monday of each month, including the summer months. The oldest member present at the opening of a meeting within 15 minutes of the specified time was to be chairman. The clerk was to be chosen at the first meeting the following January and in case he should be absent from any meeting, the youngest member present was to serve as a substitute. The methods of selecting subjects for discussion and for electing members were laid down. A fee schedule was adopted and one regulation reads that it is "desirable that bills be presented (to patients) at the beginning of the year." There were regulations for conducting consultations, rules of ethics, and a statement that physicians from abroad shall be permitted to establish their own fee table. Complaints of members were to be referred to a special committee. Absence from meetings habitually without a satisfactory excuse was to be just cause for dropping a member from the rolls. The fee schedule is a simple affair from our present day point of view. Lithotomy on the male commanded the highest remuneration, $100. Sixty-one physicians affixed their signatures to this original document. One week later the third meeting was held on Monday, September 21, at the home of Dr. Sumner and from then on to the present the Hartford Medical Society has continued interrupted for over 100 years.



George B. Hawley

Of this early group the first clerk of the Hartford Medical Society, Gurdon W. Russell, deserves a passing line or two. It has been said that "a history of Dr. Russell's professional life is practically a history of the medical profession of Hartford County for the past seventy years." Born and raised in Hartford, a graduate of Trinity College and Yale Medical School, Gurdon Russell started the practice of medicine in 1838 and retired only when he reached the age of three score and ten. His record is an enviable one. President of the State Medical Society, he early insured his life for the benefit of that organization. President of the Hartford Medical

Society after serving as secretary, director and visiting physician at the Hartford Retreat, one of the founders of the Hartford Hospital, president of its Medical Board and of the corporation, it is little wonder that history records that "this institution (Hartford Hospital) likewise, while it can record, can never pay the debt it owes to his foresight, sound



The American Hotel, formerly called The Hartford Hotel, was place where the early meetings of the Hartford County Medical Association were held

judgment and untiring energy." Gurdon Russell was a great counselor, a man of absolutely unselfish honesty and of sound financial judgment. He was fond of history, botany and arboriculture.

A few outstanding leaders in the medical profession in Hartford may be singled out in the latter half of the 19th century. There was Melancthon Storrs, who after studying at Harvard, Brown and Yale started out as a country doctor in Colchester and ended his career as a leading surgeon in Hartford. His four years of practical experience in the Civil War doubtless contributed to his ability. He is best remembered for his superabundance of physical strength, early shown in his army career when he never missed a single day from duty during the entire four years. Dr. Storrs was honored as president of the Hartford Medical Society, the Connecticut Medical Society, and vice-president of the Surgical Section at the International Congress in 1887. He served the Hartford Medical Society in the selection of a plan for and in the construction of the Hunt Memorial Building.

Another leader was that vigorous, courageous, congenial master of the spoken as well as the written word, Henry Putnam Stearns, best known to posterity as superintendent of the Hartford Retreat for many years. After graduating from the Medical Department of Yale College, Dr. Stearns studied in Scotland and Paris and brought back to this country a Scottish wife. Again he followed the pattern of so many of that day and started out in general practice, in Marlborough. During his days at the head of the Retreat he was instrumental in abolishing much of the mechanical restraint of patients formerly employed and succeeded in erecting several cottages on the grounds for the use of patients. He wrote extensively, was often on the stand in court, lectured to Yale medical students for 18 years and, unlike Melancthon Storrs who never "indulged in vacations," Henry Stearns went to Maine or Canada annually for periods of rest and recreation.

St. Francis Hospital may point with pride to one of the foremost physicians of this era, John O'Flaherty. Dr. O'Flaherty is best remembered for his part in establishing and organizing that hospital in 1897, and then serving as the presiding officer of its staff and one of its directors during the remaining brief period of his life. He came to the United States from Ireland at the age of eleven and like the true Irish gentleman that he was, became the peacemaker in many a public meeting. His practice was chiefly among the wealthier Irish families and for 40 years he conducted offices in the neighborhood of Linden Place. Evenings usually found him at home with his family. He died at the age of 62 while president of the Hartford Medical Society.

Samuel Benedict St. John became Hartford's first outstanding ophthalmologist. Born and educated in Ohio, a graduate of Yale in 1866, Columbia's College of Physicians and Surgeons in 1870, his training included Bellevue Hospital, Manhattan Eye and Ear Hospital, two years in Europe, assistant demonstrator in anatomy and instructor in chemistry at P. & S. and surgeon to Northwest Dispensary. From 1878 when Dr. St. John came to Hartford till his death in 1909 he received one honor after another. For 23 years of this period he found time to teach ophthalmology at Yale Medical School. S. B. St. John was a modest but courageous man who loved his work and contributed much to the intellectual life of Hartford's medical profession.

History recalls Harmon George Howe who was chairman of the executive committee of the Hartford Hospital when the Children's Ward, the Contagious Ward, and Wildwood Sanatorium were built. Also Oliver Cotton Smith who became one of Connecticut's most eminent surgeons. St. Francis

Hospital honored him with an appointment to the visiting staff at its opening in 1897 and two years later Dr. Smith was given a position on the Hartford Hospital staff as assistant visiting surgeon. Again we find a prominent physician passing on while a president, this time of the State Medical Society.

Two colorful figures remain to be mentioned, Everett J. McKnight and Paul Waterman. "Daddy" McKnight stomping along the corridors of the old Hartford Hospital, cane in hand, will not soon be forgotten. There are a few among us yet who recall the earlier days when, engaged in general practice in East Hartford, he pumped up and down on one of



The late Dr. Everett James McKnight of Hartford as he made his rounds in the first years of his practice in East Hartford. The picture was taken in front of a patient's house [1886]

those big rear, little front wheeled bicycles from house to house on his rounds. Dr. McKnight was an AMA casualty, for during those last two years of his life as he was rounding three score and was serving as a trustee of the American Medical Association he was obliged to make frequent journeys to Washington. This added to a busy surgical practice proved too much and he died suddenly on Christmas day 1917 of "angina pectoris," undoubtedly coronary occlusion. "Daddy" McKnight was a tireless worker. In his college days he was prominent as an athlete and was instrumental in arranging the first football game between Yale and Harvard. He served as president of the city, county and State medical societies, was a delegate to the American Medical Association for many years, and as a member of the State Society's Committee on Public Policy and Legislation worked untiringly during the sessions of the General Assembly. As Dr. E. R. Lampson has so fittingly written, he "always stood for what was right and true."

The final character in this brief sketch, Paul Waterman, should have lived on to the middle of the century but again the scourge of the profession, heart disease, struck fatally and in this instance at the early age of 46. Paul Waterman was a towering man physically and rightfully was said to have "excelled as a physician, was a citizen of highest order, distinguished soldier, fearless patriot, faithful and true friend." From his father, a distinguished surgeon in the Civil War, he must have inherited his love for the military. Enlisting as a private in the U. S. Cavalry in 1911, he speedily rose to be a major and furthered his training by attending the Army Field Service School at Fort Leavenworth. His service in World War I carried him overseas till his return to practice in 1919 as a lieutenant colonel. Then followed a busy life for the short span of four years which remained. Surgeon General of Connecticut, neuropsychiatrist to the Hartford Hospital, chairman of the State Psychopathic Hospital Commission, psychiatrist to the Hartford Board of Education, chief of the Division of Mental Hygiene of the State Department of Health, member of the State Psychiatric Board, and consultant to several hospitals—little wonder that Paul Waterman was stricken down in the prime of life! He will be remembered by many of his colleagues for his friendliness, his love of the military, and his pioneering in the field of mental hygiene and psychiatry.

Hartford physicians may well be proud of their predecessors for it is a noble heritage. Harmony, not readily maintained among any group of individualists, has characterized Hartford's medical past to an unusual degree. Scientific progress continues to be the keystone of the medical arch in this city. As one visits the great monuments of medical progress in our midst today—the American School for the Deaf, and the Hartford Retreat, now the Institute of Living, both first of their kind in America; the Hartford Hospital, the second general hospital in Connecticut, and St. Francis Hospital—one must pause, bare the head, and reverently pay tribute to our tireless and unselfish forefathers who labored long and well in the interest of humanity and for the common weal.

HYPERSPLENISM IN PREGNANCY

HENRY KROCHMAL, M.D. and MAX CAPLAN, M.D., *Meriden*

THE obstetrician is not uncommonly confronted with a medical or surgical emergency which demands immediate treatment irrespective of the presence of the pregnancy. One such surgical emergency, though rare, is hypersplenism. Its proper handling demands the close cooperation of the obstetrician, internist and surgeon. In the case we wish to present, our combined opinions were in favor of splenectomy. This was performed with a favorable outcome.

CASE REPORT

M. G., a 31 year old gravida III was seen during a routine visit for her pregnancy in September 1950. The date of her last menstrual period was 6/15/50. She offered no complaint, but on suggestive questioning admitted moderate fatigue and dyspnea on effort which she attributed to the pregnancy. Recently she noticed "a rash" around her neck and along her arms which she ignored since it did not bother her. She had two minor nosebleeds seven to eight months ago, and she bruised fairly easily, but there was no previous history of purpura, painful or swollen joints, hematuria, hematemesis, melaena, hemoptysis or abdominal pain. There had been no excessive menstrual bleeding and no menstrual bleeding since onset of the pregnancy.

At the age of 9 she had had jaundice. Her children were 7 and 4 years old. Following the birth of the first child she had a severe postpartum hemorrhage. Family history was non-contributory.

On physical examination her temperature was 98.6°, pulse 84, respirations 20, and blood pressure 115/50. She appeared well nourished and well developed and did not appear acutely ill, but was somewhat pale. Examination of the skin revealed numerous petechiae around the neck, on the chest, and on both arms. There was no generalized or local enlargement of her lymph glands. Questionable petechiae were seen in the conjunctivae. There were no hemorrhages in the fundi. There was slight bleeding in one nostril. The gums bled easily. The breasts were somewhat full, consistent with the second trimester of pregnancy. The liver was not palpable. The spleen was markedly enlarged and hard. The lower pole was palpable at the level of the umbilicus and tender. The uterus was enlarged consistent with 4 months pregnancy.

The following are the results of laboratory work done on October 15: RBC 3,560.000. hgb 11,2 Gm., leucocytes 5000, neutrophiles 58 per cent, stabs 7 per cent, lymphocytes 35 per cent, platelets 40,000, reticulocytes 0,1 per cent, bleeding time 3 minutes, coagulation time 4½ minutes, fragility normal.

Bone marrow: blast cells 0.2 per cent, lymphocytes 22 per cent, promyelocytes 2 per cent, myelocytes 3.6 per cent, metamyelocytes 7.2 per cent, stabs 22 per cent, segmented 91.6 per cent, normoblasts 18.4 per cent, erythroblasts 3.6 per cent, megaloblasts 1.4 per cent.

Urine: Clear, yellow, acid, specific g. 1010, A negative, S. negative.

Mazzini: negative.

Chemistry: NPN 28 mgm. per cent, blood sugar 92 mgm. per cent, icterus index 9.4 units, Van den Bergh direct positive, indirect 1.25 mgm. per cent. Serum albumin 3.91 Gm. per cent, serum globulin 2.33 Gm. per cent, total 6.24 Gm. per cent. Alkaline phosphatase 2.2 mgm. per cent, cephalin flocculation 4 plus, prothrombin time 100 per cent, cholesterol 133 mgm. per cent, cholesterol esters 92 mgm. per cent.

X-ray examination of the chest revealed pulmonary hypervascularization, an enlarged pulmonary artery, and an enlarged right ventricle. The impression was: hypersplenism, cause undetermined; congenital heart disease, probably interauricular septal defect.

The patient was admitted to the New Haven Hospital on 10/19/50 and a splenectomy was performed by Dr. L. C. Foster on 10/21/50. According to his operative note left paramedian incision was made. This allowed the demonstration and delivery of a spleen which semed five times the normal size. Its artery and vein were ligated and it was excised along with an accessory spleen. The liver was finely nodular, although not enlarged, and biopsy was taken. No vaginal bleeding occurred. Immediately after the splenectomy the platelet count rose to 106,000. The patient's vomitus showed a 2 plus guaiac test.

Her postoperative course, although complicated by cyanosis and dyspnea due probably to her aforementioned cardiac condition, was satisfactory. The petechiae began to fade. No new ones appeared. There was no longer any bleeding from the nose or the gums. The following table shows the favorable response of her blood count, particularly the platelets.

Preoperatively 10/15/50: RBC 3,560.000, hgb 11,2 Gm., WBC 5000, polys 65 per cent, lymphs 35 per cent, EOS 0, platelets 40.000.

Postoperatively 10/21/50: RBC 4,600.00, hgb 14 Gm., WBC 12,200, polys 80 per cent, lymphs 18 per cent, EOS 2 per cent, platelets 106.000.

Although recovery from her operation was slow in the beginning, mainly due to the difficulties caused by her

From the Medical and Obstetrical Services, The Meriden Hospital; reprinted from the Meriden Hospital Bulletin

congenital heart disease, she gradually improved sufficiently to perform her household duties. Her petechiae had disappeared rather quickly and bleding from the gums or nosebleeds did not recur. Obviously the operation was successful and no further signs of hypersplenism could be observed.

During the last month of her pregnancy she did not present any symptom referrable to her cardiac condition. She went into labor on April 1 shortly after midnight. The RBC at admission was: 4,540,000. The platelet count was: 160.000 (control: 170.000). After a very short first stage (about 2½ hours) she started to have good pushing pains which did not distress her. The second stage lasted 10 minutes and a normal female baby was delivered spontaneously. The weight of the baby was 6 lbs. 11 oz. The baby did not show any clinical signs of thrombocytopenia.

The following tables show the laboratory data on the baby: 4/1/51 RBC 6,060,000, platelets 70.000. 4/4/51 platelets 70.000. 4/6/51 platelets 80.000.

The third stage of labor was practically normal. The placenta was expelled without difficulty. The flow was slightly increased after the delivery of the placenta, but this was easily controlled with ergotrate and massage. There was definitely no hemorrhage. However, a few hours after delivery the uterus relaxed again and the flow was somewhat increased until another dose of ergotrate controlled the atony.

Subsequently her postpartum course was normal and she left the hospital in good condition on the 6th hospital day. The baby was discharged together with the mother and was obviously in good conditions too. The following table presents the laboratory data of the mother:

4/1/51 RBC 4,540,000, platelets 160.000.

4/4/51 RBC 3,660,000, platelets 200.000, WBC 13.700, neutrophiles 73 per cent, stab 2 per cent, lymphs 25 per cent, Van den Bergh 1.3, ict. index 5.8, cephalin flocculation neg., total proteins 6.06, alb. 3.38, globulin 2.68.

It is interesting that 3 days postpartum the cephalin flocculation test is negative and the icteric index practically normal, in contrast to the examination done prior to her operation, at which time the cephalin flocculation test was 4 plus and the icteric index was markedly elevated, which facts were consistent with the diagnosis of Banti's disease. At the time of this writing the baby is eight weeks old and mother and baby are doing well.

The report of the examination of the operative specimen is as follows:

A small piece of liver tissue, (the liver biopsy) shows an increased amount of fibrous tissue which is centered mostly in the portal areas. The portal areas appear unusually cellular and there appears to be recticulum cell hyperplasia. These cells are extremely numerous along the sinusoids. The liver cells are fairly well glycogenated. No evidence of fat is seen.

The spleen is very large, measuring 15 by 10 by 7 cm. and weighing 790 Gm. Externally the capsule is smooth and shiny and the organ has a peripheral red appearance. It is slightly lobular and fairly firm. The hilar area does not appear remarkable. On cut section the surfaces are fairly dry, firm and deep red and the Malphigian corpuscles are somewhat distended but fairly small. The trabeculae are not distended. Very small slightly linear yellowish areas are seen which appear as tiny flecks throughout the spleen. These are probably the thickened vessels. On microscopic examination the capsule is not unduly thickened. Some of the vessels are considerably thickened. One, in the section presenting the yellow area seen grossly, is seen to contain large amounts of black material, probably representing metallic pigment. The lymph follicles are somewhat indistinct but appear at the same time to be fairly large and there is lymphoid hyperplasia throughout the pulp. The reticulum cells are likewise apparently hyperplastic and some of the macrophages contain red cells. Considerable fibrosis is present throughout the section. A few hemorrhages are noted here and there. Megakaryocytes are quite numerous.

Pathological diagnosis: 1. Liver showing minimal fibrosis and recticulum cell hyperplasia; 2. Fibrosis, lymphoid and recticular hyperplasia, megakaryocytes, phagocytosis of red cells and hemorrhages.

Clinical diagnosis: hypersplenism secondary to congestive splenomegaly (Banti's syndrome).

PATHOGENESIS

The term "hypersplenism" was first used by John H. King[1] in 1914 in discussing the functions of the spleen. At that time he spoke of "important clinical symptoms that disappear or are strikingly mitigated when the spleen is removed from the body." Doan, Wiseman and Damashek[2,3,4,5,6] have broadened our conception of this phenomenon, and have popularized the term "hypersplenism" so that it now is recognized as a clinical entity.

For centuries it has been known that the spleen can alter its size.[1] Its capsule and trabeculae are made up of dense fibrous and elastic tissue as well as smooth muscle fibers which allow it to expand and contract. "Within its splenic pulp spaces," according to Bockus[7] who quotes Whipple and Klemperer, "the free blood circulates and the blood is stored or filtered for varying periods coming in contact with the phagocytic white blood cells and lining reticulo-endothelial cells." There is, thus, a reservoir in the spleen for a fairly large amount of the total circulating blood, and, according to the "sequestration" theory of Doan,[8] the type of formed element of the blood which is phagocytized there will determine the syndrome which the hypersplenism will present. If red blood cells are destroyed in sufficient amount, the syndrome of hemolytic anemia is produced. That this destruction has actually taken place in the spleen can easily be proven experimentally by analyzing the bilirubin content of the splenic artery and vein, and noting its increase in the venous

blood. When the leukocytes are destroyed in these pulp spaces, splenic neutropenia results. In the same way, the increased destruction of large numbers of platelets leads to purpura. Panhematocytopenia is the state in which large numbers of all the formed elements of the blood are destroyed. Bone marrow studies show that these elements are present in normal or increased numbers and that there is no maturation arrest,[9] and studies by Doan and Zollinger[10] on blood in the splenic vessels before and after injection of adrenalin again confirm these views.

While Damashek[11,12] agrees that hypersplenism is a real entity, his explanation of the mechanism is somewhat different, in that he believes that the decrease in one or more of the formed elements of the blood is due to a hormonal inhibitory action on the bone marrow by the spleen, and that this may be selective or include all the elements to cause panhematocytopenia. Only aged red blood cells are actually destroyed in the spleen according to Damashek's concept. He therefore classifies the blood dyscrasias in the following way:

1. Thrombocytopenic purpura will result if the inhibitory effect on the platelets only is exaggerated.

2. Splenic neutropenia will result if there is increased inhibition of delivery of granulocytes.

3. Splenic pancytopenia will result if there is increased inhibition of all blood elements.

4. Splenic pancytopenia with hemolytic anemia will result if there is also increased destruction of red blood cells.

CLASSIFICATION

Doan and Wright[5,9] have classified hypersplenism into primary and secondary types. The primary type which is described by them as a "hyperinstability" of the spleen may take the form of an acute or chronic disease. It may be initiated by minor trauma, mild infection, or normal pregnancy; it may be spontaneous as congenital hemolytic jaundice. Besides congenital hemolytic jaundice, the primary form may include thrombocytopenic purpura, splenic neutropenia, and splenic panhematocytopenia.

According to these same authors, the secondary form consists of "normal instability plus unusual pathological stress." In these cases the hypersplenism accompanies other diseases such as the leukemias, tuberculosis of the spleen, sarcoid, syphilis, malaria, Gaucher's disease, tumors of the spleen, cirrhosis of the liver, congestive splenomegaly (Banti's syndrome) and Felty's syndrome.

PATHOLOGY

The pathology of hypersplenism has been described by E. Von Haam and A. J. Awny.[13] From their histological studies of 134 spleens removed from hypersplenic patients they found a focal to a diffuse increase of reticuloendothelial cells throughout the pulp. They also found an increase of the reticuloendothelial cells in the perifollicular zone with stagnation or sequestration of the blood elements in the pulp of the sinusoids. The blood elements which had been missing from the peripheral blood were present in small clusters in various degrees of disintegration in the distended sinusoids and throughout the pulp. They did not believe that phagocytosis alone was a basis of hypersplenism. This concept disagrees with that of Doan and Wiseman[2,3,4] who felt that the increased phagocytosis was the most important phenomenon.

DIAGNOSIS

Damashek and Estren[11] consider the following triad for diagnosis: 1. depleted blood; 2. splenomegaly; and 3. full marrow.

Doan[9] lists five criteria for the diagnosis: 1. diminution of one or more of the circulating blood elements; 2. normal or increased bone marrow activity; 3. splenic enlargement; 4. increase in the number of deficient blood elements after injection of adrenalin; and 5. complete and rapid recovery after splenectomy.

Damashek also considers splenectomy as a final diagnostic test for hypersplenism but he does not feel that the adrenalin test is of conclusive value. Both of these authors consider hypersplenism as a functional rather than an anatomic diagnosis.

RESULTS

The results of splenectomy in primary hypersplenism are usually very good. Thus Damashek and Welch[12] found in their study of 216 cases of blood dyscrasias from 50 to 100 per cent good results with splenectomy. These results varied from 100 per cent in congenital spherocytic anemia to 50 per cent in the acquired hemolytic anemia group. The results in the secondary form of acquired hemolytic anemias were not as good, since only 33 per cent of the patients had a favorable outcome. In the secondary form of splenic pancytopenia and neutropenia there were 71 per cent good results with splenectomy, while 81 per cent of the primary type of these blood dyscrasias did well.

In another paper, Damashek and Estrin[11] state that

if the diagnosis of hypersplenism is correct, splenectomy may be expected to cure the hematological abnormality in about 80 per cent of the cases. Doan[9] reports 176 cases of splenectomy for primary hypersplenism with very good results. Forty-nine of these cases were primary splenic thrombocytopenic purpura, and in all but 5 of them there was an increase of circulating platelets on the day of splenectomy. Thirty-five per cent of his cases were patients with secondary hypersplenism and many had similar good results after splenectomy. Lahey[14,15] too considers that splenectomy is definitely indicated and with striking and lasting results in splenic neutrapenia, pancytopenia, idiopathic thrombocytopenic purpura, and familial hemolytic jaundice. Epstein, Lozner, Cobbey, and Davidson[16] discuss three patients with purpura hemorrhagica who were subjected to splenectomy and have maintained normal platelet counts for 2, 3, and 13 years, respectively.

In the secondary form of hypersplenism one can only expect or hope for cure of the hematological condition but not of the underlying cause. Many of the symptoms which these patients are suffering from are related to the hypersplenic phase and these symptoms may be alleviated. Therefore there is no unanimity of opinion on the value of splenectomy in secondary hypersplenism. Rousselot[17] considers many of these conditions as those in which the operation may be indicated, but accepts congestive splenomegaly in which he believes splenectomy is definitely indicated. Pratt[18] has stated that splenectomy is primarily indicated in several conditions including splenic anemia and Banti's disease. Hunter and Kiernan[19] have reported excellent results in leukemia complicated by hypersplenism, and quote 53 cases of splenectomy performed on leukemic patients by Dr. W. J. Mayo in 1926 long before our conception of hypersplenism was fully understood. Splenectomy has usually been considered to be contraindicated in leukemia but when symptoms of hypersplenism appear it is definitely beneficial.

A review of the literature on splenectomy in pregnancy by McElin, Mussey, and Watkins[20] shows only 53 cases reported, to which they add 5 others. They clearly show that, in spite of the pregnancy, the results of splenectomy are excellent in primary hypersplenism. If splenectomy is performed the course of gestation for either congenital hemolytic jaundice or for primary idiopathic purpura, the outlook for mother and baby is excellent if pregnancy progresses to term. The results in the secondary form of hypersplenism are very much less favorable, maternal death occurring in 3 of their 6 cases of Banti's syndrome.

A case of pregnancy complicated by idiopathic thrombocytopenic purpura and sarcoid disease of the spleen was reported in February 1946 by Nordland, Ylvisaker, Larsen, and Reiff.[21] Their patient had a splenectomy performed during the fifth month of pregnancy and she went on to deliver a normal infant at term.

There is some difference of opinion as to when splenectomy should be done in pregnancy. Wolff and Limarz[22] state that splenectomy is best done following the pregnancy and during a remission of the disease, but may be performed in the first trimester. All these authors state that pregnancy does not contraindicate splenectomy when the hematological picture demands it. Barnes and Doan[23] suggest that the indications for splenectomy are similar to those in the non pregnant woman. Most of the others authors we quote consider splenectomy as an emergency procedure which must be done irrespective of the trimester.

Pregnancy following splenectomy for primary hypersplenism does not carry much hazard. There is considerable risk if the splenectomy was done for secondary hypersplenism such as Banti's syndrome.

SUMMARY

A surgical complication of pregnancy, hypersplenism, is discussed with presentation of a case which responded favorably. Some of the literature of this rare subject is reviewed with particular reference to the results obtained with splenectomy.

BIBLIOGRAPHY

1. King, J. H.: Arch. Int. Med. 14:145, 1914.
2. Doan, C. A., Curtis, G. M., and Wiseman, B. K.: J. A. M. A. 105:1567, 1935.
3. Wiseman, B. K., Doan, C. A., and Wilson, S. J.: J. A. M. A. 115:8, 1940.
4. Wiseman, B. K., and Doan, C. A.: Ann. Int. Med. 16:1197, 1942.
5. Doan, C. A., and Wright, C. S.: Blood. 1:10, 1946.
6. Damashek, W., and Miller, E. B.: Blood. 1:27, 1946.
7. Bockus, H. L.: Gastro-Enterology. Vol. 3, W. B. Saunders, Philadelphia, 1946.
8. Doan, C. A.: J. Lab. and Clin. Med. 30:385, 1945.
9. Doan, C. A.: Bulletin of N. Y. Acad. Med. Vol. 25, No. 10, page 625, 1949.
10. Quoted from 9.
11. Damashek, W. and Estren, S.: Med. Clin. N. A. Vol. 34, No. 5, September, 1950.

12. Welch, C., Stuart, and Damashek, W.: N. E. J. Med. Vol. 242, No. 16, 1950.

13. von Haam, E. and Awny, A. J.: Am. J. Clin. Path. 18:313-322, April, 1948.

14. Lahey, F. H.: Surg. Clin. N. A. Vol. 28, No. 3, June, 1948.

15. Lahey, F. H.: Surg. Clin. N. A. Vol. 29, No. 3, June, 1949.

16. Epstein, R. D., Lozner, E. L., Cobbey, T. S., and Davidson, C. S.: Am. J. Med. Vol. 9, No. 1, July, 1950.

17. Rousselot, L. M.: Surg. Clin. N. A. Vol. 29, No. 2, April, 1949.

18. DeWeerd, J. H., Pratt, J. H., Hagedorn, A. B.: Proc. Staff Meetings, Mayo Clinic. Vol. 25, 12, June 7, 1950.

19. Hunter, O. B., and Kiernan, P. C.: Post. Grad. Med. Vol. 8, No. 3, Sept., 1950.

20. McFlin, T. W., Mussey, R. D. and Watkins, C. H.: Am. J. Obst. Gyn. Vol. 59, May, 1950.

21. Nordland, M., Ylvisaker, R. S., Larson, P. and Reiff, R.: Minnesota Med. 29, Feb., 1946.

22. Wolff, J. R., and Limarzi, L. R.: Am. J. Obst. and Gyn. 51, 1946.

23. Barnes, A. C., Doan, C. A.: Am. J. Obst. and Gyn. 55, May, 1948.

24. McFlin, T. W., Mussey, R. D. and Watkins, C. H.: Proc. Staff Meetings, Mayo Clinic. Vol. 24, No. 25, 1949.

CONDUCTION DEAFNESS IN CHILDREN

A Study of 400 Children, Ages 3 to 12 Years

PAUL B. MACCREADY, M.D., *New Haven*

The Author. *Associate Clinical Professor, Otolaryngology, Yale University School of Medicine*

THIS study was made for a local group of pediatricians who had referred most of these patients. Since it explained many of the conflicting views in regard to the tonsils and adenoids which play such an important role in this type of deafness, it was felt of sufficient interest to warrant its publication. It would seems that the terms "auto-immunization" and "filters" have crept into the literature to produce a practice on the part of some pediatricians which is not entirely to the welfare of the patient.

Conduction deafness results from lesions which interfere with the normal movements of the middle ear ossicles in their transmission of air-borne sound waves to the inner ear. There are three common lesions which interefere with ossicular mobility. First there is osteogenic fixation of the footplate of the stapes in otosclerosis, a lesion which is irreversible but which can be by passed by a fenestration operation. Secondly, there is fibrosis of the mucosa of the middle ear such as to interfere with the normal ossicular movements, principally by dense fibrous adhesions. This is the result of prolonged stoppage of the eustachian tube or of a chronic suppurative otitis media and it too is irreversible. Thirdly, any lesion which causes obstruction to the eustachian tube will interfere with the normal movements of the ossicles. This process, at least in its earlier stages, as seen in children, is a reversible process.

While adenoid tissue in the nasopharynx is the principle cause of the tubal obstruction in children, the obstruction is not purely mechanical as might be visualized. It is essentially an inflammation, with a resulting edema of the mucosa and hyptertrophy of the mucous glands at the nasopharyngeal end of the eustachian tube. The mucosa of the middle ear becomes hyperemic and edematous as a result of the negative pressure in the middle ear caused by absorption of the air by the moist walls of a closed cavity. If this condition persists for a long time or is aggravated by repeated low grade infections, fibrosis of the edematous mucosa results in permanent interference with the ossicular change.

The purest example of conduction deafness due to obstruction of the eustachian tubes is seen in aero-otitis media. This is an acute traumatic inflammation of the tympanum caused by a difference of pressure between the air in the middle ear and that of the surrounding atmosphere. In a power dive by a pilot when the eustachian tube fails to open, an acute hemorrhage into the tympanic mucosa may result. In most instances the trauma is not so severe. The symptoms depend, however, upon the duration and severity of the barotrauma sustained and vary from pain and stuffiness of the ear to marked deafness.

The principal therapeutic measures for the treatment of conduction deafness in children are first the removal of the tonsils and adenoids and secondly the use of radium in the nasopharynx where surgery is insufficient because of its effect on the lymphoid tissue in and around the eustachian orifice. The role of antibiotics and the question of allergy must be considered. Do the tonsils play any role in immunity? Why not just remove the adenoids? This all requires a knowledge of the function of the tonsils and adenoids.

Since we are dealing with an early condition which may not seem too important at the time, the question is often asked, "would it clear up if nothing was done?" From its very nature the answer would be no. In several instances in this series the operation was deferred for various reasons for a period of months, without any clearing of the conduction deafness. The use of antibiotics before the removal of the tonsils and adenoids failed to clear up the condition in any of the patients in this series.

DIAGNOSIS

In conduction deafness of every type, hearing is better by bone conduction than by air conduction which is the reverse of normal. Until the later stages of deafness, the hearing by bone conduction is good.

In the present series of children between the ages of 3 and 12 years, the diagnosis was made by means of the pure tone audiometer and the use of light magnesium alloy tuning forks. It should be pointed out that the majority of these children were brought in by their parents because they wanted to know if they were deaf or just inattentive. A few were discovered accidentally by the screening tests done in the public schools. A tuning fork of 512 frequency or higher would readily establish the relationship of air conduction to bone conduction. Pure tone audiometer tests could be done on most of the patients, even those three years of age. Speech testing was too time consuming and did not aid in the diagnosis, so was discontinued. As all auditory testing at present is purely subjective, the consistency of performance in the several tests is the best indication of their correctness. The impairment shown by means of the air conduction audiogram was for the most part "flat"; where it was "tilted down" in the high tone range, the changes in the bone conduction indicated some possibly accompanying nerve involvement but this was uncommon.

ROLE OF THE TONSILS AND ADENOIDS

Because of the proximity of the adenoids to the eustachian tubes, the question constantly arises, why not just remove the adenoids? There are occasional cases where the tonsils are not infected where the removal of the adenoids alone would be enough and each case should be judged on its merits individually. But there are several reasons for the removal of the tonsils along with the adenoids in most cases.

Much of the mouth breathing seen in children is caused by the tonsils rather than the adenoids although it is difficult for those not present at the operation to understand this. In many cases of mouth breathing the surgeon is often disappointed at the small size of the adenoids in comparison to the enormous hypertrophy of the tonsils. Removal of the adenoids in most children would not relieve the inflammation in the nasopharynx and the attendant over stimulation of the mucous glands in the surrounding mucosa. This is purely a clinical observation.

Much has been written about the protection given the child by leaving the tonsils in and the term "autoimmunization" has been coined. Is there any real basis for this? Scattered throughout the membranes of the pharynx and much of the alimentary tract and some of the respiratory tract is a whole system of subepithelial lymphoid tissue. The cases of mesenteric adenitis which neither the pediatrician nor the surgeon can accurately differentiate from acute appendicitis represents an involvement of part of this system. The tonsils and adenoids are not separate organs—they are merely collections of this subepithelial lymphoid tissue. They form such an infinitesimal part of the system that their removal can in no way impair the immunity function which is alluded to so often.

The lymphatic tissue of Waldeyers ring (palatine, lingual and pharyngeal tonsils, aggregations of lymphoid tissue around the eustachian tubes, on the posterior pharyngeal wall, on the posterior surface of the tongue, in the pyriform sinuses and larynx) form an extensive surface of contact between it and the epithelium. The basic unit is a crypt formed by the inversion of epithelium and surrounded by a layer of lymphatic tissue in which are "secondary nodules." One of the finest pathological studies of the tonsils was made back in 1925 by Tanaka and Crowe.[1] Their illustrations clearly show the rela-

tionship of the afferent and efferent blood vessels to this very thin epithelium.

The secondary nodules were first described as "germinal centers" and were supposed to have a hemopoietic function in the production of lymphocytes. While they may produce lymphocytes this is a very minor function since the nodules do not appear until after birth. Then the secondary nodules were considered "reaction centers," furnishing a defense against toxic and bacterial irritants which have invaded the epithelium. This is probably the correct interpretation. In the alimentary and respiratory tracts these nodules are separated from the outside world by a single epithelial layer and exposure to bacteria may be constant. Hence the term "autovaccination" was coined. The whole subject was reviewed in a very scholarly manner by Waldapfel[2] back in 1947.

It would seem there is a real basis for the term auto-immunization if the subepithelial lymphoid system as a whole is considered. When limited to such a small part as the tonsils there is no sound basis for this hypothesis. When the cervical glands (glands at the angle of the jaw which drain the tonsils) remain enlarged in the absence of any sinus infection, it is obvious that the first line of defense in the tonsils has been eliminated. Hypertrophy of the lymphoid tissue on the back of the pharynx following a tonsillectomy is not an indication of attempt to replace any protective function of the tonsils. It indicates a persisting sinus infection or an allergic response or a lowered blood iodine. The use of antibiotics during acute infections of the pharynx in children as advocated by those claiming autoimmunization as the reason for not removing the tonsils would seem to be poor medicine. If the tonsils are to be permitted to function as an autoimmunization factor, no antibiotics should be given to the children which is not the reasoning generally followed.

Finally there is the economic reason. With the high cost of medical care, one does not feel justified in advising two separate hospitalizations as would be necessary, if one will suffice. This, too, is purely a clinical observation that a tonsillectomy is frequently necessary within one to two years after an adenoidectomy has been done and parents always feel it should have been done the first time. The removal of the tonsils and adenoids is a very unpleasant experience for the youngster today. Yet, if it will prevent the development of a permanent deafness, it is justified and it would seem poor medicine not to give the child the benefit of this procedure.

USE OF RADIUM IN THE NASOPHARYNX

The use of radium in the nasopharynx to reduce the lymphoid tissue in the fossa of Rosenmueller and around the eustachian orifices where surgery is not sufficient, has provoked a controversy more emotional than factual. This work was begun by Crowe and his associates and carried on for twenty-five years.[3,4,5,6] It had been known for a long time that lymphoid tissue was highly sensitive to irradiation whether produced through x-ray or radium. Observations were made on the use of x-ray[7] but that had certain disadvantages of concentration and the necessity of passing first through normal tissue. Radium could be applied at the desired point and the possibility of injury to surrounding structures minimized. Burnam[4] aided in working out a standard dosage too small to cause injury yet strong enough to affect the lymphoid tissue. The dose used is calculated at 25,000 mg. seconds for the standard monel metal applicator (70 per cent beta and 30 per cent gamma radiation). The usual dosage is three irradiations of 12 minutes' duration spaced two weeks apart. This method of treatment was given to thousands of pilots (14,000) in the Air Force in World War II, to sailors (700) in the submarine service, and to several hundred school children in Baltimore. Not a single case of burn or other complication due to the radium has been observed and many patients have been followed for 10 to 15 years and some for 20 years.[8] The scare reports have been argument by analogy. Not a single case of cancer of the nasopharynx developing after this type of irradiation has ever been substantiated. The one big criticism has never been brought out in all the furor over the danger in the use of radium—namely an adequate series of control cases. This is now being remedied.

Recently there appeared an article in the *J. A. M. A.*[9] on the use of x-ray treatment and its supposed advantages over the use of radium as outlined above. There seems to be a misconception of the amount of lymphoid tissue in the eustachian tubes on the part of these authors and also of the nature of the process producing conduction deafness. Reference is made to some ulceration produced by the use of radium. Considering the thousands treated by Crowe and his associates without any such affects one wonders if the ulceration might not have been due to trauma? X-ray even as used by these authors

is not without danger. It was my fortune to see one of the x-ray treated patients we reported back in 1922,[7] thirty years later. She had had no x-ray in the interim yet the skin of her neck was terribly discolored and pigmented by that original x-ray treatment as a child.

Radium as used for this treatment is figured on the basis of distance. It cannot affect excessive lymphoid tissue which is more than a few millimeters lateral to the eustachian orifice. The exposure is limited even more by midline adenoid tissue and hence is never used until all gross adenoid tissue is removed surgically. In this series only those who did not clear up with the surgical procedure were treated with radium and then only for the three treatments. Apparently many of the physicians will give a fourth treatment after a period of six months has elapsed. Haines[10] gives as high as six treatments of 10 minutes' duration. Crowe and Bordley[11] feel it is possible to renew the series of 3 irradiations after a year has elapsed and the desired results were not obtained. This has not been done in any patients in this series.

USE OF ANTIBIOTICS

In some patients the conduction deafness persists despite removal of the tonsils and adenoids (and often a second adenoidectomy), and the use of radium. Crowe and Bordley[11] have had two patients respond to massive doses of antibiotics when both surgery and radium failed. The use of antibiotics before surgery has not proven efficacious in reversing the process in conduction deafness. The author has had two children in this series in whom this was tried several months after radium had failed to clear up the deafness completely. They both cleared up after an intensive series of penicillin injections for five days. Whether this will hold through another winter cannot be stated at this point. One additional patient received no benefit from this treatment which was not done under my observation.

PRESENT SERIES

It has been variously estimated that 80 per cent of the deafness in children stems from diseases of the upper respiratory tract. In order to arrive at an estimate for this particular type of conduction deafness 400 consecutive tonsillectomy and adenoidectomy operations were studied. The children ranged in age from 3 to 12 years. Children under 3 years do not tolerate a tonsillectomy as readily as the older children so that the operation is restricted to children of 3 years and over.

This series is an average series. The tonsils and adenoids were removed for the local trouble they cause: mouth breathing, recurrent tonsillitis, recurrent otitis media, persistent cervical adenitis, poor nasal drainage, etc. There were no cases of purulent sinusitis. No operations were done for diseases in other parts of the body or general diseases or for focal infection. Of course, conduction deafness should be included as a criterion for the operation as was done in this series. The patients were referred for the most part by pediatricians and general practitioners. This excluded any frank outspoken cases of allergy. Most of these children had had antibiotics for various acute infections. This is pointed out for its relation to so called "auto-immunization" and to emphasize the fact that in itself antibiotics will not prevent the development of conduction deafness.

There were no postoperative aspiration sequelae, lung abscess, pneumonia or bronchitis, since the whole operation was devised to prevent that. Postoperative bleeding occurred in 2 per cent of the cases but was readily handled. With the advent of the polio teaching and change in the time of year for doing tonsillectomies and advent of the extensive use of antibiotics the postoperative bleeding has increased considerably since this series was done.

RESULTS

Conduction deafness was the indication for the removal of the tonsils and adenoids in 25 per cent of the cases. This was a fairly consistent figure for a three year study and would probably be in that neighborhood for most any series. This provided 100 patients with conduction deafness for special study.

Of the 100 patients with conduction deafness, the deafness cleared up in 80 within 3 months of the operation. In the majority of these the return to the normal relationship of hearing by air conduction better than by bone conduction occurred within the postoperative convalescent period of three weeks. Of this group 4 have had subsequent attacks of otitis media within a year of their operation. In 3 this cleared up without leaving any residue of conduction deafness. There is no late report on the fourth patient who moved from this area.

The remaining 20 represented the more severe and long standing cases. Several had had their tonsils and adenoids removed two or three years previous. A second adenoidectomy followed after an interval by radium was the treatment in these. Three were complicated by recurrent otitis media. Three were cases not representing pure conduction deafness.

Five patients cleared up within one year of their operation. At the end of three months the bone conduction was better than air conduction but this had become normal at the end of one year. Their audiograms were at the lower border of normal—most children will hear some of the speech frequencies above the zero base line. Their audiograms were mainly between 5 and 10 db. with no frequencies below 10 db.

Four patients moved to another area and there are no late observations. These four were similar to the above in that there was only a minimal loss as shown by the audiogram but the bone conduction was better than the air conduction when last observed.

Eleven patients had radium treatment with none of the spectacular results obtained in a larger series which included many adults, and many patients with chronic otitis media. Two patients cleared up in one ear but not completely in the other. An intensive series of antibiotics in these two for one week as suggested by Crowe and Bordley cleared up the deafness in the remaining ear and this has persisted normal for over six months. A third patient had his radium treatments by another doctor without much success and then later was given a similar series of antibiotic treatment. Subjectively he is fine and the mother doesn't notice any deafness but his ears have shown no improvement in the upper half (higher frequencies) of the tone range so that the patient is probably suffering with a mixed type of deafness. Two patients were diagnosed mixed deafness before treatment. The lower half of the tone scale came up within normal range while the higher tones did not. One patient with a previous mastoid operation cleared up in his good ear but showed no improvement in the previously operated ear. Another with chronic bilateral otitis media has dry ears but apparently the process was of too long standing as the hearing has not improved. The three remaining cleared up within six months of the radium treatment and now have normal hearing.

CONCLUSIONS

1. Conduction deafness in younger children is much more common than previously supposed, occurring in 25 per cent of the children in an average series referred to have their tonsils and adenoids removed.

2. Conduction deafness is an indication for the removal of the tonsils and adenoids, clearing up in 80 per cent of the cases by this one procedure.

3. Radiation of the nasopharynx by radium in the standard monel metal applicator is a helpful supplementary treatment without danger when properly used.

4. The misconceptions about the tonsils and adenoids as "filters" and as a source of "auto-immunization" have been reevaluated to prevent the persistence of a harmful practice in medicine.

BIBLIOGRAPHY

1. Tanaka, M., and Crowe, S. J.: Direct Blood Stream Infection Through the Tonsils. Arch. Otolaryn, I, 510 (May) 1925.

2. Waldapfel, R.: The Tonsil Problem. Arch. Otolaryn, XLVI, 318 (September) 1947.

3. Crowe, S. J., and Baylor, J. W.: The Prevention of Deafness. J. A. M. A. CXII, 585 (February 18) 1939.

4. Crowe, S. J., and Burnam, C. F.: Recognition, Treatment and Prevention of Hearing Impairment in Children. Ann. Otol. Rhino. & Laryn. L, 15 (March) 1941.

5. Haines, H. L., and Harris, J. D.: Aerotitis Media in Submariners. Ann. Otol. Rhino & Laryn. LV, 347 (June) 1946.

6. Bordley, J. E.: The Use of Radium in the Treatment of Conduction Deafness. Surg. Gyn. & Obs. LXXXIV, 839 (April) 1947.

7. Waters, C. A., MacCready, P. B., and Hitchcock, C. H. S.: Roentgen-Ray Treatment of Chronically Infected Tonsils and Adenoids. Am. Jour. Roentgen. IX 469 (August) 1922.

8. Personal communication from S. J. Crowe.

9. Garland, L. H. et al: Nasopharyngeal Irradiation. J. A. M. A. CXLVI 454 (June 2) 1951.

10. Personal communication from Haines.

11. Personal communication from Crowe and Bordley.

THE ROLE OF UREA-SPLITTING BACTERIA IN UROLITHIASIS

Description of a Simplified Urea-Agar Medium for Their Detection

Fred C. Collier,† M.D., Alfred Reich, B.S., and John W. King, M.D., *Cleveland, Ohio*

The clinical significance of micro-organisms in the urine and their possible role in the etiology of urolithiasis has been recognized since the breakdown of urea by bacteria was first described by Louis Pasteur in 1862.[1] Alteration in hydrogen ion concentration is intimately related to urolithiasis. Cystine, xanthine and uric acid crystals appear in acid urine, and calcium and phosphate salts are precipitated from alkaline urine. The presence of urea-splitting organisms in the urinary tract has been reported many times.[2,3,4] These organisms must be indicted as the cause of urinary calculi in both acidic and basic urine, for in the review by Suby & Suby, urea-splitting bacteria were incriminated in renal calculi irrespective of urinary pH. Within the last thirty years several investigators have produced urolithiasis by inducing urinary tract infections.[5,6,7,8] The importance of this is patent when it is realized that this disease is one of the few in which Koch's postulates have been fulfilled.

Many organisms are capable of hydrolyzing urea, and the usual methods of classification are of no aid in determining the urea-splitting ability of a particular organism in question. All strains of *Proteus* fall into this group as do some strain of *Pseudomonas*, *Escherichia*, and *Staphylococcus*.[9] A report of renal calculi formation in patients who were subjected to prolonged immobilization demonstrated concurrent urinary tract infection in which 18 per cent of the rod-shaped bacteria and 40 per cent of the staphylococci isolated as etiological agents were capable of hydrolyzing urea.[10]

The best clinical classification of the offending organisms in cases of urinary infections is made on the ability to produce urease. Such classification can be effected easily by adding urea to an appropriate medium. Urea decomposes when autoclaved so it has been thought necessary to sterilize it by a filtration technique and add it to the previously sterilized basal medium. Because this type of differential medium is employed not only for urological cultures but also as a means of detecting pathogenic bacteria in stool cultures, its widespread use has made desirable simplification of the previously technically difficult preparation of such media.

Such simplification has been effected in this laboratory by the dry sterilization of urea crystals. Two-tenths of a gram of urea is placed in a Petri dish and heated to 125° C for two hours in an oven. This has proved to be an effective sterilization procedure. Since urea is heat-stable under 131.7° C, decomposition of the urea does not occur. To this sterilized urea is added 20 ml. of the following basal medium.

Bacto-tryptose	10	
Glucose (C.P.)	5	
Bacto-agar	15	
Phenolphthalein (1 per cent alcoholic solution)	2	5
Distilled water	1000	

In actual practice many urea containing Petri dishes are sterilized simultaneously and wrapped in groups of three. These dishes may be kept for a period of months without contamination. The modified tryptose-agar is dispensed in 20 ml. amounts and autoclaved. When needed the basal agar medium is melted and after careful cooling is poured into the Petri dishes containing the urea as the need arises for this culture medium. Phenolphthalein is used as an indicator because it is felt that an alkaline reaction is more easily identified than by using phenol red.

SUMMARY

The role of bacteria in the etiology of urolithiasis is stressed, and the importance of some of these bacteria in producing alkaline urine is mentioned. Urine may be rendered alkaline by the action of certain bacteria on urea, hydrolyzing this to form

†Present address: Institute of Pathology, College of Medicine, The Ohio State University, Columbus, Ohio.

From the Department of Clinical Pathology of the Cleveland Clinic and the Frank E. Bunts Educational Institute

ammonium carbonate. The presence of these urea-splitting organisms is a predisposing factor in the production of urinary calculi. Identification of these organisms is accomplished easily through the addition of urea to a suitable medium incorporating a pH indicator. It is not possible to sterilize media to which urea has been added; for this reason in the past filtered urea has been added to previously autoclaved media. The technique is described of sterilizing the urea in an oven and adding the previously autoclaved media to the sterile urea. It is felt that this procedure is of greater simplicity than the method currently in general employ.

Portions of this work were made possible by a grant from the Harkins Medical Research Foundation.

BIBLIOGRAPHY

1. Pasteur, L.: Ann. Chem. et Phys., Ser. 3, 64:5-344, 1862.
2. Hellstrom, J.: Urologia Treviso, 16:144-145, 1944.
3. Suby, H. I., and Suby, R. M.: J. Urol., 57:995-1000, 1947.
4. Kimbrough, J. C., and Denslow, J. C.: J. Urol., 61:837-852, 1949.
5. Rosenow, E. C., and Meisser, J. G.: Coll. Papers of Mayo Clinic, 13:253-256, 1921.
6. Hager, B. H., and Magath, T. B.: J. Amer. Med. Assoc., 85:1352-1355, 1925.
7. Boshamer, K.: Arch. of Orthop. v. Unfall.-Chir., 32:84-95, 1932.
8. Higgins, C.: J. Amer. Vet. Med. Assoc., 118:81-85, 1951.
9. Rustigan, R., and Stuart, C. A.: J. Bact. 49:419-436, 1945.
10. Brown, R. K. L., and Earlam, M. S. S.: Aus. and N. Zeal. J. Surg., 3:157-171, 1933.

OSTEOCHONDROMATOSIS OF THE HIP JOINT

WALTER A. DALMAIN, M.D., *Bristol*

The Author. *Attending Orthopedic Surgeon, The Bristol Hospital*

A fifteen year old female was seen at The Bristol Hospital complaining of a painful left hip with inability to walk without pain, to get up from a sitting position, and stiffness of the hip. She was admitted to the hospital on July 14, 1951 giving a history that one week prior to admission she suddenly felt the pain, without any apparent cause. Her past history was essentially negative. She had the usual childhood diseases and a tonsillectomy at age 3. She did state that about five years ago she had a transient pain in the hip which subsided without any residual symptoms. Examination on admission revealed a well developed and nourished female who walked with a marked limp and stiffness of the left hip. She was unable to clear the floor with the left foot and because of pain could walk only a few feet at a time. Active and passive motion was markedly limited in all directions and the patient held the hip in flexion and adduction. There was no muscular atrophy of the thigh or calf. Reflexes were active and equal. There was no sensory disturbance of the left lower extremity. The laboratory work-up was normal including the sedimentation rate. The findings on the roentgenogram are shown in Figure 1 and Figure 2.

On July 19, 1951 an arthrotomy of the left hip was done through an anterior iliofemoral incision. The capsule was incised longitudinally with a transverse incision at the attachment on the medial portion. The synovial fluid was increased and as the incision was made in the capsule the loose osteocartilaginous bodies began to extrude themselves. Two hundred and twenty six loose bodies were removed. This was done by the use of saline irrigations, rotation of the hip so as to force the bodies to migrate anteriorly, and with a fresh glove a thorough digital examination was made. The greater portion of the calcified bodies were lying posteriorly and medial. The head of the femur was smooth and the synovial membrane was thickened. A roentgenogram at operation confirmed the removal of the bodies. The patient made an uneventful recovery and was discharged on August 6, 1951. Check up examination on August



FIGURE 1
Roentgenogram of both hips. Note osteocartilaginous bodies in the left hip



FIGURE 2
Left hip—Multiple calcified bodies fillling the entire hip joint. Femoral head normal and the joint space not narrowed

13, 1951 revealed a normal range of motion and no pain. Figure 4 is a roentgenogram taken postoperatively.

Osteochondromatosis in this case was of the synovial chondroma type. The synovial fringes may undergo cartilaginous transformation for the cartilage cells of the villus may take on true tumor growth with the formation of chondromata which later become detached into the joint cavity. Most authors believe that trauma contributes in some degree to the formation of these bodies. The loose bodies will not re-form provided the process is at an end at the time of surgery and if they are removed at the opportune time, since secondary osteoarthritis will develop due to articular joint damage. The result is excellent if operation is done early and at the time when the bodies are free in the joint.

Mussy and Henderson reported the distribution of affected joints with 70 per cent occurring in the knee and 22 per cent in the elbow. The involvement of the hip is not common and in a patient of 15 years it is rare, which makes this case interesting and worth reporting.

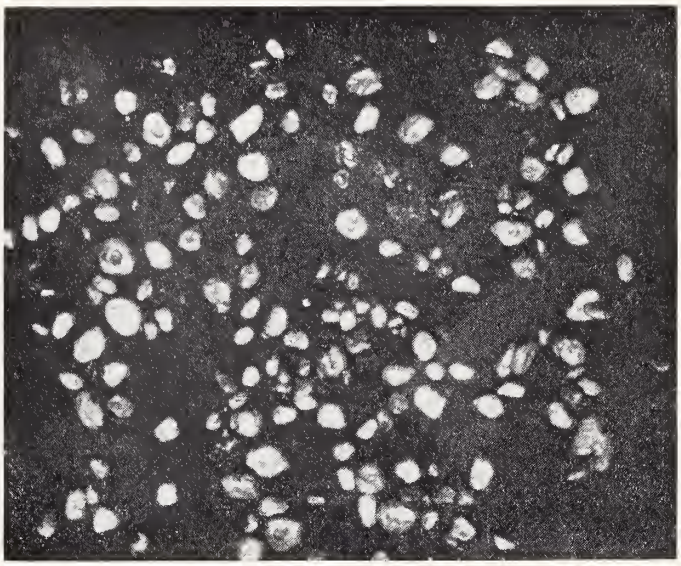


FIGURE 3
Osteocartilaginous bodies which were removed at operation numbered two hundred and twenty six bodies measuring from 2 mm. to 1.5 cm. in size



FIGURE 4
Roentgenogram of both hips after operative removal of the calcified bodies

Note: Grateful acknowledgement is given to A. A. Beatrice, M.D., of Bristol, for the privilege of treating this patient.

REFERENCES

1. Campbell, W. C.: Operative Orthopaedics 1939. C. V. Mosby Co., St. Louis, Missouri.

2. Mercer, W.: Orthopaedic Surgery 1938. Edward Arnold & Co., London, England.

3. Mussy, J. R., Jr., Henderson, M. S.: Osteochondromatosis. J. Bone & Joint Surg. Vol. 31 A, 619-627, July, 1949.

THE STRUCTURE OF FEE TABLES IN MEDICAL SERVICE INSURANCE

William H. Horton, M.D., *Windsor*

The Author. *General Manager and Director of Medical Services, Connecticut Medical Service, Inc.*

Practicing physicians in the future will be much more concerned with schedules of specified fees for their professional services than they have been in the past. Many physicians feel that any fee schedule represents an unwarranted intrusion upon the independence of individual practice and they generally regard the increased use of schedules as against the best interests of medicine. It must be admitted that a schedule does represent something of a restriction upon practice, but that fact in itself cannot alter the current trend of medical care which clearly indicates that more, rather than less, use will be made of them. Then too, the admission that schedules place some limitations on practice does not necessarily condemn them for there are many aspects of fee schedules, most of which are not ordinarily considered by practicing physicians, which are definitely helpful to medical practice.

An insistent demand for the "best" is characteristic of American life. In recent years it has been coupled with an equally insistent demand that the "best" be obtained with the least possible effort and expense. It was inevitable that medicine, the most conservative of all thinking groups, should eventually be called upon to provide a more systematic and equitable basis for medical care than had been obtained in the traditional physician-patient relationship. These circumstances required that medicine find a basis for providing the services demanded, and at a cost which was within the reach of all, or face the fact that the people would take any steps necessary to secure these ends, most of which would be unfavorable to medicine, and some of which might eventually result in its complete dissolution. Medicine was confronted with "change."

Change, however, as Dr. Cline, president of the American Medical Association, pointed out in New Haven several months ago, must not be rejected simply because it is change. "Every change must be judged on two bases," said Dr. Cline and I quote him, "First, is it a constructive change which will be of benefit to the medical welfare of the people? And second, does it respect the legitimate interest of the profession? If the answer to either one of these questions is 'no,' then it is a change we should oppose and oppose on the basis of principle. If the answer to both questions is 'yes,' then that is a change which we can embrace and wholeheartedly support."

When we consider all factors pertinent to the present trends in medical care, there can be no question but that prepaid medical care provides a "yes" to both of Dr. Cline's questions. It is, therefore, a change which all of medicine must embrace and wholeheartedly support. Physicians must understand that this change involves the economic side of medicine as well as the professional. Let us look into fee schedules which are a necessary component of any prepaid medical care program.

It is as futile to cite the undesirable effects which fee schedules may have on medical practice as it is to rage against the present trends of American life. We may better spend our time and efforts in attempting to improve the schedules under which the physician will practice; they are, and will continue to be, an integral part of the practice of medicine.

Now what is wrong with present day schedules? I feel that the fairest comment is that they seem to create as many problems as they solve. Some physicians think there is nothing wrong with them except that the fees are not high enough; others think that the fees for their work are not too high but the fees for other types of specialists certainly are. The patient thinks that some fees may be too high, or that it doesn't make much difference because the doctor will charge more anyway as soon as he knows you

Presented at a Symposium on Prepaid Medical Care, Council of the New England State Medical Societies, Boston, Massachusetts, November 18, 1951

have insurance; or that the fee is too low, particularly if he is under *service benefits* and is not liable for any personal payment.

The insuring agency is interested in the actuarial side of the picture; good experience with a satisfactory premium; low utilization of high payment procedures and little concern for high utilization of services with only nominal payments. The commercial carriers are operating an industry whose interests are not primarily medical, and which may or may not be identical with those of the profession. The individual Blue Shield plans have yet to find the answers to some of the questions posed by the rugged individualists of medical practice.

I believe that it is possible to eliminate many of the current difficulties by the establishment of a uniform basic fee schedule for professional services to the lower income group. The most important need of American medicine on the economic side is a professional services index. That is, a listing of all professional services indicating their relative values to each other. If such an index were established, and I believe it can be done, we would have a uniform framework for the establishment of a fee schedule anywhere in the country. The amount of money to be paid for any particular procedure is simply a matter of interpreting the index into dollars on any basis desired.

Now a basic fee schedule cannot be nationwide, because I believe if it is correctly constructed it is dependent on the income level of the area which it serves; the professional index is not so limited, for it deals in relationships rather than dollars. Thus, if an index were constructed and used throughout the country the fee paid for a T & A in Arizona would be in the same proportion to the fee paid for an appendectomy there as would the fees paid for those two operations be here in Boston, regardless of the actual amounts of money involved. The advantages of this situation are obvious.

If we did have the professional index, how would we determine the amount of money to be paid as the maximum fee? This brings to mind several considerations that find ready application to our current practical fee schedule problems, as well as to the hypothetical professional index schedule. The more I have thought out the problem, the more it seems to me that we do not make a great deal of sense to our lower income patient when we have a variety of fees for the same operation, depending upon who is going to pay for it.

It is the ethical responsibility of the profession to render all necessary services to all members of society without regard to their financial capacity. This is the precept that distinguishes medicine as a profession; when it no longer is a reality, medicine becomes a trade. With this regard for the patient in the background, when he does bill his patient, the physician must necessarily have his fee bear a very direct relationship to the total amount of money which the individual has for the total support of his family situation. This means that the fee charged will usually not reflect the actual value of the services rendered by the physician, much less the value of the services to the patient. It does, nevertheless, represent a reasonable charge against the total income at the disposal of the patient for the care of himself and his family.

This "reasonable" charge which our physician is making is the charge which must be in our uniform basic fee schedule for the lower income group. The amount of money which our lower income patient will be required to pay for an operation must not differ from that which would have been paid for him, had he had Blue Shield protection, and received *service benefits*.

In revising our CMS contract last April we got started in this direction by stating the Basis of the Fee Schedule which I will quote in part: "This Schedule of Surgical Operations contains fees which are considered by Connecticut physicians to be reasonable charges for the professional services specified, when rendered to Subscribing Members who are entitled to *service benefits*. The fees do not necessarily indicate the usual cost of the operation or the full value of the professional services which are rendered. The fees in general are lower than customarily charged in private practice and this differential represents a specific contribution by the Participating Physicians of CMS to the personal welfare of their patients."

We feel that such a basis for a fee schedule reflects the philosophy of medicine as a profession, and translates the idealism of medicine into practical reality for the patient. A man, whose income of $3,400 a year must support his wife and two children, and who is confronted with the expense of a radical hysterectomy for his ailing wife, cannot possibly pay the usual charge of a surgeon on Bay State Road, on Park Avenue, or for that matter in Granby, Connecticut. Nor should he have to! The medical profession has undertaken the responsibility to re-

store this woman's health without consideration of the cost. The Blue Shield Plan has undertaken to enable this man to protect himself against the full cost of the operation, through the willingness of the Participating Physician to live up to the traditions of his profession. This is as it should be!

We must remember that the patient is entitled to have the proper surgery properly performed, and since there can be only a single standard of surgery, it is of no moment from the patient's point of view whether the operation was performed by the best Boston, New York or Granby surgeon or a mediocre surgeon there or elsewhere.

Most of the difficulties which physicians experience with fee schedules arise from the fact that they forget the basis on which the schedule was arranged and think in terms of what the operation is worth to them; the medical service plan is (or should be) dealing in reasonable charges in relation to income. And the situation should be no different if the patient does not have prepaid insurance.

The third requirement for the construction of our optimal fee schedule is that it must be prepared by, or with the approval of, the physicians who will do the practice. There are a great many eager beavers and professional do-gooders who are all too willing to tell the doctor how to practice his profession; already too many have had a hand in shaping the course of medicine. There is no one more capable of developing a satisfactory equitable medical care program, for both the patient and physician, than the practicing physician himself, if he will take the time to interest himself in the problem. If he does not, I am sure that eventually he will find the job has been done for him, but probably not to his liking.

I should like to cite a trend which may have far reaching implications; it will be to pose a problem to you, not to supply the answer for I am sure I do not know it.

In two and a half brief years, CMS has been able to exert a very healthy influence on the charges of practicing physicians for their services to the lower income group. This, of course, was possible only through the complete cooperation of the participating physicians. We now find that some labor negotiations are seeking settlements involving surgical contracts in Connecticut, identical with those made elsewhere in the country. This is in effect, establishing a sort of national fee schedule, which as I have stated, I do not believe is sound because the amount of money paid for surgery should be related to the income. As the union gains more and more benefits over the bargaining table, the employer seems less and less interested in the type of benefit and more interested in the cents-per-hour negotiations.

The union wants the "best" and there appears to be no limit to what it will eventually demand and receive, as long as the current inflationary trend continues. It now seems that just when Connecticut physicians are assuming, more than ever, their proper professional responsibilities to their patients, some of them are going to be able to collect much more for certain operations than they can under the CMS contract.

What is to be done when surgeons decide that, on the basis of their professional obligations to their patients, $175 is a reasonable fee for a cholecystectomy when performed on a man earning less than $4,500 a year, only to find that the patient as a result of labor-management negotiations is entitled to $300 from his commercial insurance carrier for having had the operation? What happens to the "reasonable" charge? If $300 is felt to be a proper charge for the commercially insured man, even though the "reasonable" fee is $175, how about the man who has no insurance, but the same income? Are we not being forced into the untenable position that if a man has no insurance at all or if he is covered by a prepaid non-profit medical plan sponsored by the physician and his colleagues the fee paid by such a plan is adequate compensation, but if the man is insured under a commercial insurance program (arranged as a result of labor-management negotiation) it is all right for the surgeon to receive an additional fee for the identical operation?

Are labor and management the ones to decide a surgeon's fee? Can the professional services of surgeons be delivered through the medium of labor-management negotiation like a political voting block? I do not know how reliable labor and management are, but I do know that surgeons as a group, any more than individuals, cannot serve both God and Mammon! It is not possible, in the tradition of medicine, for the physician to present to the public a schedule of "reasonable" fees to persons within the lower income groups, and then accept higher payments for such services when the interests of third parties are best served by creating increased fee schedules. In such a situation the physician be-

comes a pawn of labor, management and the commercial insurance company. The schedule of fees which are to be paid him is decided for him without his consultation or consent. These circumstances may appear to be salutary to medicine at present, unless they are well studied, since higher fees are being paid. In the future, however, when the economic situation is such that fringe benefit programs of manufacturers (health and welfare benefits) must be sacrificed in order to maintain the best possible living wage, the physician will be less pleased with the results of labor-management negotiations as far as his surgical fees are concerned.

I still believe that the physician who performed on a lower income group patient, the radical hysterectomy referred to previously, should receive exactly the same amount of money for the operation whether he is paid from the man's own funds, from CMS, or from a commercial insurance carrier. Medicine has never been a notable success in the public relations field but during the past two years has pulled itself up by the boot straps to gain substantial support of public opinion. This support is in grave danger of being lost, with little likelihood of being regained, if medicine permits itself to be controlled, even though profitably, to suit the purposes of others. Over 33,000 people have taken the trouble to write to CMS in appreciation of the physician's services rendered them under our program and we have covered only 82,000 odd claims. We are liable to be the "fall guy" of third party interference between patient and his physician if we permit this outside manipulation of fee schedules and disrupt the best public relations that have ever existed for medicine.

In summary, I believe that most fee schedule problems may be solved by the creation of a professional service index; by the direct relation of fees to income levels, and by having the schedule arranged by, or with the approval of, the physicians who must practice under it. There are many ways in which outsiders may intrude upon the private practice of medicine, and it is incumbent upon every practicing physician to be vigilant in protecting each and every aspect of his practice. Everyone seems bent on doing something for, to, against, about, or with, the practicing physician; or as Durante would say, "everybody wants to get into the act!"

THE MIDDLE MAN IN PHYSICIAN-HOSPITAL RELATIONS

Leland S. McKittrick, m.d., *Brookline, Massachusetts*

I appreciate the opportunity that is mine in coming to New Haven and discussing with you a problem so fundamental in a program which calls for continuing improvement in the quality of medical care given to the public; increased efficiency both in the giving and in the receiving of that care, and active support of our voluntary prepayment plans. I have chosen the title because I believe that so many times the fellow I have referred to as the middle man—in other words the patient—has been left by the wayside, temporarily at least.

Little will be gained by a historical review of the continuing and now very feverish controversy between the medical profession on one hand and hospital administrators on the other.

I would like to go just far enough back to remind you that in 1946 the Council on Professional Practice of the American Hospital Association with Dr. Robin C. Buerki as chairman, prepared a set of principles on this same problem. These principles were approved by the Board of Trustees of the American Hospital Association, The American College of Surgeons, representatives of the various specialty groups, (anesthesiology, radiology and pathology) and the Council on Medical Education and Hospitals of the American Medical Association. "These Principles of Relationship Between Hospitals, Radiologists, Anesthetists and Pathologists emphasize that the primary obligation of both physician and hospital is to serve the best interest of the patients. This the committee believed led to a fundamental principle that decision as to the ethical or unethical

Presented at the New Haven County Medical Association, New Haven, October 25, 1951

nature of practice must be based on the ultimate effect of good or ill on the public as a whole. These principles also recognized the basic fact that all of the various questions involved in the relationship between physicians and hospitals, both legal and ethical, must be considered in the first instance at the local level because of the various differences which of necessity exist in many sections of the country. Again the committee believed that this gave us another fundamental principle that consonant with established principles of medical ethics, local conditions must decide the various arrangements and conditions of practice with reference to both hospital facilities and medical personnel and their relationships." (Quote from Report of Committee on Hospitals and the Practice of Medicine American Medical Association, June 1950.) These principles, it seems to me, are as fundamental and as sound in 1951 as they were in 1946. Nothing has happened which has in any way altered the fundamental principles established in this report. But like so many reports implementation has been lacking.

As many of you know, we in Massachusetts were thrown into somewhat of a crisis in 1947 when Blue Cross introduced its so-called comprehensive contract offering complete coverage for the cost of the services of these specialists for patients in the private rooms of our hospitals. In May of that year the New England Roentgen Ray Society passed a resolution which was introduced in the Council of the Massachusetts Medical Society and which resulted in the appointment of a committee to define hospital and medical services and to develop a program whereby more satisfactory relations might be established and maintained between hospitals and physicians.

The committee appointed included representatives from the Medical Society, the various specialty organizations—Blue Cross and Blue Shield, and the Massachusetts Hospital Association. They worked long and hard through a very hot summer, but finally submitted a unanimous report to the Council of the State Society in October of that year when it was promptly accepted.

I will not go into the details of that report. Suffice to say that it defined clearly the difference between medical and nonmedical services rendered in hospitals and reemphasized the basic concept that whatever the financial arrangements between physicians and hospitals might be, there must not be exploitation of the patient by either party. Again this report was hailed locally as an excellent report, pointing the way to a better future. Once again, implementation was lacking and now there is merely one more report in the records of the Massachusetts Medical Society.

We have had too many resolutions at a high level and too little effort locally. The more official action we take, the farther apart we become. Thus in March 1950 the American Hospital Association passed a resolution entitled "New Resolution on Hospitals and The Practice of Medicine." This stated in part "Resolved, that radiological, pathological, anesthesiologic and physiatric services are included properly in a patient's day of hospital care; and be it further

"Resolved, that services rendered by physicians in radiologic, anethesiologic and physiatric departments of hospitals be included in prepayment hospital service plan subscribers certificates." This resolution after all of the time and effort which had been expended previously in attempting to bring closer together these two important groups certainly was waving a red flag in front of the bull.

In June of the same year the House of Delegates of the American Medical Association counterattacked by amending the report of the Special Committee on Hospitals and the Practice of Medicine (Hess) to include a paragraph which read: "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by any agency for a fee." This, then, is where we were in June 1950. The two most important national organizations responsible for giving medical care to our nation, each dependent upon the other and both committed to a common cause, about as far apart as two groups could possibly be.

Now with this as a background let us consider the important practical aspects of the subject under discussion. However justified or for whatever reason, there is at the present time throughout various sections of the country an intolerable situation in relation to those physicians who have gone into the specialties of radiology, anesthesiology and pathology on the one hand and with the hospital administrators on the other. No good can possibly come from this. A solution must be reached. The time to begin is now, the place to begin is here at a local level, and the way to begin is for us as physicians to study the various aspects of the problem; to sit in

conference first with each other, in order that we may come to some reasonable agreement among ourselves. When we have done this, and not until then, we should sit down with hospital administrators and governing boards to the end that we may all come to understand each other and our mutual problems. At the head of each conference table there should be a placard reading—"What is best for the patient will be best for us."

The three specialties most seriously involved: radiology, pathology and anesthesiology, are the keystone to good medicine and are essential to proper care of hospital patients. These specialties differ somewhat from what we might for the moment call the clinical specialties such as surgery and internal medicine, because in general they function in a consulting capacity or to put it better, their responsibility to the patient is largely through another physician. The anesthetist has a specific job to do for the patient who is operated upon. It is usually of short duration and once completed his responsibility to the patient ceases. The roentgenologist is called in most frequently to make special examinations in the hope that an accurate diagnosis can be made. In therapeutic radiology the relationship of the roentgenologist to the patient more nearly approximates that of any other consultant such as the surgeon. Since the services of all of these specialists must be readily available to every patient in the hospital, regardless of the condition for which he or she entered, it is natural that in our larger hospitals the full time of one or more of these physicians is needed in each department. It is quite natural then that the work of these specialists be particularly identified with hospital care.

In previous years when the financing of hospitals was an easy problem, when hospital administrators had no worries, and there were no prepayment plans, the relationship between these groups and hospital administrators was satisfactory—at least in our section. As hospitals became pressed financially, however, and particularly with the advent of prepayment plans and especially Blue Cross, the physicians going into these specialties found themselves more and more in the position of being in the employ of the hospital. They were often referred to, even by the clinicians, as the hospital radiologist or the pathologist, rather than Dr. Smith or Dr. Jones; so that probably very few patients recognize the fact that this group represented highly specialized physicians playing a very important role in their welfare. With the increasing pressure being placed on hospitals for financial survival every possible avenue of income was carefully screened. The income from these three specialties in most of our larger institutions was large. The salaries paid to the men were usually good, but often not in keeping with the increased income of the department. There was reason to suppose that money being paid for specialty examinations was over and above that needed for the financial support of this particular specialty and that excess funds were being turned in to the general treasury of the hospital to help lessen the deficit. Also the inclusion of these services by Blue Cross led to the suggestion that in many instances Blue Cross boards were responsible for setting the charges and controlling to some degree the conditions under which these men worked. The several specialty societies, therefore, usually stimulated by a grievance of some particular member became activated and very loud in condemnation of the trends.

From what I can learn, there are certain demands which those specialists feel are entirely in keeping with the integrity and dignity of the medical profession. They point out with great concern the shortage of well trained men in all of these specialties, and are disturbed at the lack of good young men applying for positions in the resident training programs of the country. They believe that (1) If I, as a patient, go to X hospital and if during that hospital stay I require x-ray examinations, I should be charged no more for those examinations than is necessary to adequately pay the roentgenologist and to compensate the hospital for the expenses involved. In other words, they feel that I am not fairly treated if the charge for my examination is unnecessarily high in order that some part of what I pay goes to support some other branch of the hospital. This, they say, is exploitation of the patient and of the physician and is not in accord with established medical ethics. (2) As a roentgenologist, an anesthesiologist or a pathologist, I am a physician practicing medicine just as truly as is the surgeon, the pediatrician or the internist. I render equally valuable services to the patient. Being a professional man does something to me that cannot be put in words. That is one reason I went into medicine. I want to remain a professional man, I want to be recognized as a professional man not only by the hospital administrators and boards of trustees, but also by the patients I serve. I do not want to be classed with the other employees of the hospital, and be anonymous

to the patient who receives the bill. I want the same relationship to the hospital as that of my medical and surgical friends. I want to feel that if I do my job well, if I am ethical and if I put in extra effort, I will be compensated financially for this effort (though not in excess), that tenure of office will depend upon the same considerations as does that of the other physicians, and I want to be under the same rules and regulations as the medical staff as a whole. I want to send my own bills in my own name. In other words I ask nothing that is not accepted as proper for the other physicians on my hospital staff. (3) Blue Cross pays for hospital services not for medical services rendered to patients by physicians. I believe in prepayment plans, but payment for my services should come from Blue Shield or other Medical Service plan, not from Blue Cross.

The hospital administrator, on the other hand, may well say that he is required by the American College of Surgeons to have these departments if his hospital is to be approved. The responsibility for this is upon his shoulders. The medical staff in the past has depended upon him to supply them with the services of these physicians. He feels that it is confusing to the patient to have a bill from the hospital for board and room, a bill from the pathologist, a bill from the roentgenologist, a bill from the anesthetist, a bill from the surgeon and a bill from any other consultant coming to the hospital. It is far simpler for the patient, causes less confusion and makes for better relationship between the hospital and the public, if for those services he can render a single bill. He sees no harm during these days of stress when survival of voluntary hospitals is essential if compulsory health insurance is to be avoided, in taking modest amounts from an income producing department such as these specialties may be, and utilize it to support the nonincome producing departments of the hospital. This he feels is sound business. He is ready to admit that it may not be good permanently, but this is not the time to create further financial complications for him and his hospital.

The Board of Directors of Blue Cross say that for years it has been customary in this section of the country for charges for the work of these specialties done in the hospital to be included on the hospital bill. Blue Cross and Blue Shield are the main bulwark against Compulsory Health Insurance. If the latter is to be avoided, the former must grow to include the greater part of the population. At the present time the removal of these specialties from Blue Cross would seriously hamper our selling program and might well jeopardize our success. Until such time as Blue Shield more nearly approximates in membership that of Blue Cross, it would be contrary to the welfare of the public to suddenly eliminate from Blue Cross benefits, those particular ones which in a costly illness mean so much to the patient. By accepting Blue Cross payment on a basis of cost to the hospital for services rendered to patients in semi-private accommodations, there is no possible way that the physician can be exploited by Blue Cross, nor is there any way in which Blue Cross can be instrumental in setting the charges made by these specialists.

Now why don't you sit down around the table with me. Let us take these somewhat divergent views, and see if we cannot more or less agree on the more important principles involved.

To begin with we all share the concern of these groups relative to the shortage of well trained men in the three specialties and are quite willing to agree that the present unsettled state in the hospital-physician relations may be a factor in the lack of good applicants for the resident training programs. We agree to the importance of an early solution to the problem and wish to combine our efforts to develop the best possible conditions, physical and professional under which these men will work. We also agree that these specialists are physicians, they are highly specialized physicians, they are fundamental to good medical care and in all probability are the greatest single influence in the high quality of medical care in any hospital and, therefore, in the community. They are entitled to the professional recognition of the other clinicians on the staff. They should be appointed in the same way that the other staff members are appointed. If their services are satisfactory, if they are ethical in their practice, they should have available to them the same privileges as are available to the rest of us.

On the other hand this presents somewhat of a problem. If I as an internist find the work of one of the surgeons to be unsatisfactory, I will change my surgical consultant. According to the set-up in my hospital there is not work enough for more than one radiologist. You really have a monopoly on the work here. What am I and my confreres to do if your work does not seem to be up to par? You have the necessary professional requirements, you are ethical. It is not easy for me, a colleague, to start a

movement to have you dropped from the staff and someone else appointed. To be sure you are one of us in every sense of the word and should be recognized and treated as such, but nevertheless there is this one fundamental difference which places a very real responsibility upon you when you accept such an appointment. How are we and our patients to be assured that you will develop and maintain a high quality of service for us at all times?

I am sure we can agree that it is not fair to overcharge the patient for his x-ray examinations in order to help pay the laundry bill for the hospital as a whole. May it not be that hospitals in the past have been unrealistic in their attitude towards the public? Does it really make good sense for one hospital to advertise its rate as $11 per day and have the patient end up paying an average of $19.06 a day. And have another hospital in the same community charge $14 per day for the same facilities and have the patient pay a total of $19.12. Other things being equal, the public will naturally prefer the $11 hospital; whereas they could go to the $14 hospital and have it cost them only six cents more per diem. Of course, the answer is a higher charge for the ancillaries and the answer to that is that probably the ancillaries are helping to support the board and room. Could you as a hospital administrator justify this to the patients who are going to your hospital? Don't you think that the time has come to face this a little bit more realistically and let the public know what it is going to cost them and not have any hidden taxes? But in any case can we not agree that it is wrong, I might even go so far as to suggest it is dishonest to charge my patient more for his x-ray than is necessary to adequately support the department so that the hospital deficit might be lessened? The poor fellow has had a pretty tough time as it is. I really don't think he would understand or like this if he knew!

Now as to sending your own bill—unfortunately you men in the specialties within the hospitals do not have to face the patients who are coming in to our offices. They do not bring to you their complaints as they do to us and as they also do to the hospital administrators whom they hold responsible for everything that happens in the hospital. Do you really think that it makes good sense for the patient to get a separate bill for everything that goes on in the hospital. Those of you who live your entire professional lives within the hospitals must be intimately interested in the welfare of your own hospital and the people it serves. Don't you think that it would be better to have your bill included along with the hospital bill? Certainly, if we are to improve the efficiency with which our care is given to the public, we must diminish not increase the number of bills they get. That is what we at the Massachusetts General Hospital are now trying very hard to do in the development of our so-called Associates. We want patients to get one bill for all of their professional services. Why not then let the hospital send the bill, let them collect the money for you, but in doing this they must put on that bill the name of the person or head of the department who is rendering the service. In other words, on that bill must go the name of the pathologist, should he have offered a service, the name of the roentgenologist, etc. We at the Massachusetts General Hospital have had them collect our fees at the Baker Memorial since 1928. This has been highly satisfactory. We have had no criticism of it, it has not done anything to me as a surgeon, it has not lessened my prestige, it has not made me feel obligated to the hospital, nor has it given me an inferiority complex. It has just increased the efficiency of our service and as a matter of fact probably a higher percentage of my bills have been collected by the hospital than I would have collected had I sent them myself. Can't we compromise on this? Have your name appear, be a physician like the rest of us but let the hospital send the bill.

Now this Blue Cross situation is a bit more complicated. There is no question but what fundamentally and eventually Blue Cross should completely restrict its payment for nonmedical services rendered in hospitals. On the other hand, we must remember that you and I are paying good money and fighting hard to beat off Compulsory Health Insurance. Blue Cross was the vanguard in this battle. It has had troublesome times, it is far from perfect but it is rapidly improving and rapidly expanding. It is essential, however, that it grow and that it grow rapidly. Blue Shield which should rightfully pay for all of the professional services is still far behind Blue Cross, in the number of subscribers, and to suddenly increase costs of hospitalization for Blue Cross subscribers by eliminating all of these services at the present time would seriously affect the patients and be cause for great dissatisfaction. It would seem to me that maybe for the moment, if Blue Cross limited its payment to cost for services in semi-private accommodations, there could be no exploita-

tion of the patient or of the physician. If and when the Blue Shield in a given area more nearly approximates the subscriber list of Blue Cross, and if and when hospital cost accounting will make it possible, it should then be no problem to do what is entirely proper and that is make the shift. As a matter of fact there is no reason that I can see, why at the present time anesthesia, except that given by nurses in the employ of a hospital, and therefore a non-medical service, should not be completely eliminated from Blue Cross at the present time. It would not seriously jeopardize their program. It would prevent Blue Cross and Blue Shield patients both paying for the same services. It would keep Blue Cross subscribers from paying for something most hospitals do not offer. Why not begin by dropping anesthesia from Blue Cross now and having Blue Shield begin to take up the slack?

Now comes this question of payment—actually if your department sets the rates for your services, if they are such as to adequately cover all expenses including your income, if no money collected from your services is used for any purposes except those for which it was intended, what difference does it make how you and the hospital work it out? If you as a teacher are interested in developing your department, if you wish to be on a given salary and turn back into your own work additional funds that you, through your own efforts, have earned—should that not be your privilege? I know today certain hospitals in this country giving excellent services in communities that could not possibly be given except through the generosity of their staffs. It does not seem to me that the details of the financial arrangements are important if the fundamental principles are preserved.

We are all here to serve the public. Our primary obligations are to them. If we plan and live our professional lives in such a way as to best serve our patients, our problems will disappear. Much, if not most, of our present difficulties come from failure of us as physicians and of hospital administrators and governing boards to understand each other and our mutual problems. Hospital trustees are, for the most part, successful, capable, public spirited men and women. They are giving freely of their time and efforts to the community through their hospital. They have grown up in a different world from us. They need to understand us—we need to understand them. My own experiences with hospital administrators and governing boards make me feel very strongly that if and when we, as physicians, sit down with representatives of the governing boards of our hospitals, not with an attitude of distrust and antagonism, but with a determination to give and take in a dispassionate constructive way, we will come to know each other and to understand our common problems. Then, and only then, will the "Specialty Problem" disappear and we can all work in complete harmony for the welfare of our patients.

In closing then let me repeat—we have had too many resolutions, too few serious attempts to solve our individual problems at the local level. The next move is yours and mine—here in our own community not there in some far away city.

ANNUAL COUNTY ASSOCIATION MEETINGS

Fairfield, Tuesday, April 8

STRATFIELD HOTEL, BRIDGEPORT

Business meeting 4:30 P. M. Dinner 7:00 P. M.

Speaker: Alex Raymond

Subject: "SIGNIFICANCE OF THE COMIC STRIP IN TODAY'S SOCIETY"

Middlesex, Thursday, April 10

COMMODORE MACDONOUGH INN, MIDDLETOWN

Business meeting 4:30 P. M. Speaker and subject to be announced

Tolland, Tuesday, April 15

OLD HOMESTEAD INN, SOMERS

Dinner 6:30 P. M. Business meeting 8:30 P. M.

Speaker and subject to be announced

Windham, Thursday, April 17

NATHAN HALE HOTEL, WILLIMANTIC

Dinner 6:30 P. M. Business meeting 7:30 P. M.

Speaker: Dr. Karl T. Phillips

Subject: "TWENTY-FIVE YEARS OF SURGERY IN A SMALL HOSPITAL

Litchfield, Tuesday, April 22

CONLEY INN, TORRINGTON

Dinner 7:00 P. M. Social hour 6:30 P. M.

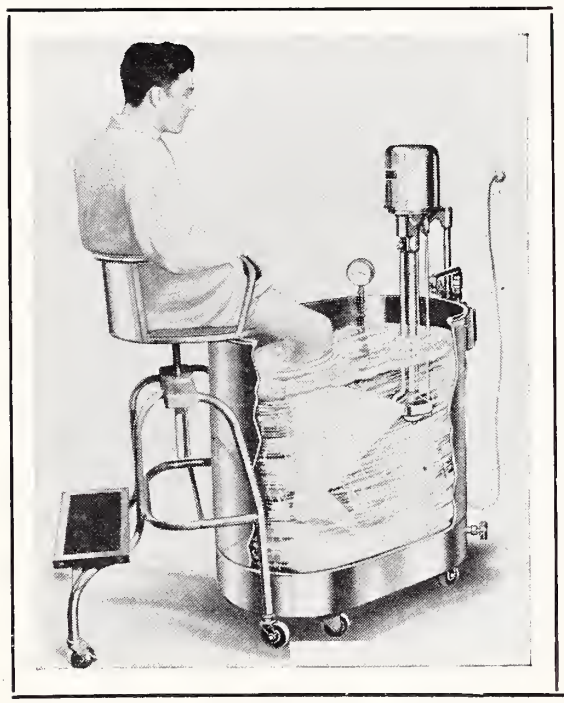
Business meeting will follow dinner

Speaker: Dr. Lewis Garston

Subject: "DRUG AND CHEMICAL SENSITIZATION"

American Surgica

Let real "team spirit" serve you . . . That's just what our entire staff o
. . . from the first contact of our sales representative right through
tinuous interest and satisfactory service.



from

the

ILLE LINE

of

PHYSICAL THERAPY EQUIPMENT

COMBINATION ARM, LEG AND HIP TA

(Improved Whirlpool Bath) Mobile Model HM-200. Partic
practical for office or hospital use as this mobile unit does not r
plumbing connections.

Picture shows mobile adjustable chair for use with leg treatment.

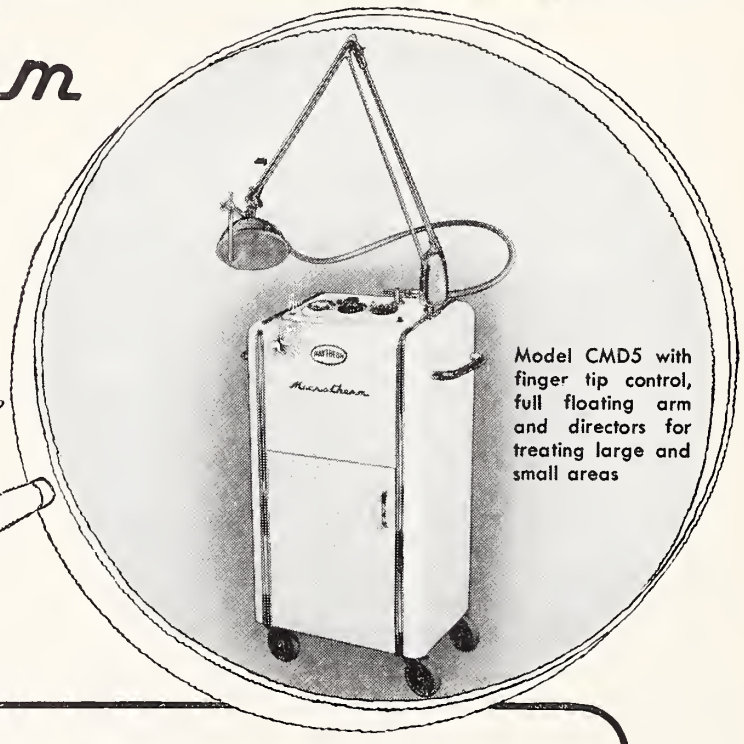
American Surgica

SUPPLY AND EQUIPMENT COMPANY : 1715 BARNUM AVENUE : F

BEFORE YOU INVEST in Diathermy Equipment
INVESTIGATE Raytheon's Up-To-The-Minute

Microtherm
RADAR DIATHERMY





Model CMD5 with finger tip control, full floating arm and directors for treating large and small areas

Here are some of the outstanding features of Raytheon Microwave Diathermy

1. No television interference. *Microtherm* employs the "radar" wave length — way above the TV wave length.
2. A high degree of absorption
3. Penetrating energy producing deep heating
4. A desirable temperature ratio of fat to vascular tissue
5. Effective production of active hyperemia
6. Desirable relationship between cutaneous and muscle temperature
7. Controlled application over large and small areas — 3 directors provide central or peripheral heat and precisely radiating areas as small as 3 or as large as 150 square inches — a finger tip control Dazor floating arm assures maximum flexibility
8. Elimination of electrodes, pads and danger of arcs
9. No contact between patient and directors

Are you willing to be shown? Ask us to demonstrate the Microtherm shown above and the New D Director for Larger Areas i.e.:—on an entire extremity and from the base of the neck to the coccyx, or transversely to irradiate the lumbar sacral area or to treat both shoulders simultaneously.

50 BRIDGEPORT, CONN. TELEPHONES 5-3116 or ENTERPRISE 3190

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
BENJAMIN V. WHITE - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Cancer Control Month

Once again the month of April, designated Cancer Control Month by Congressional Resolution, brings into sharper focus the attack on cancer by the American Cancer Society in research, education, and service to patients. The continued success of this great organization in collecting dollars and putting them to work of the highest advantage reflects fine credit upon those who are controlling its destinies. Voluntary subscriptions by the American people to the support of such a cause as this, given in increasing measure and good-will is an impressive demonstration of the fact that we like to do things for ourselves. The vast army of workers for the Cancer Society from directors to solicitors who give their time freely in this great service, shows too the deep personal interest that our people have in everybody's fight. Doctors have a most unique opportunity to help for their wide knowledge and deep interest in this subject is the most important single influence in keeping the public informed of the continued progress in the attack on cancer. You don't have to be an acrobat to put a shoulder to the wheel and a hand in your pocket.

Group Catastrophic Illness Insurance

It is now assured that the group catastrophic insurance coverage for members of the Society will go into effect on April 15. There is still time to file an application and it should be addressed to Arthur W. Eade, 185 Church Street, New Haven, Connecticut. All members of the Society have received the details of this contract and the response has been quite satisfactory. To the best of our knowledge, such insurance has never before been offered to a medical society group. If you are not familiar with the details, highlights of the coverage are given below.

1. Q. Who will underwrite this special medical expense policy?

A. The Commercial Insurance Company of Newark, New Jersey, a member of the Group of Companies known as the "Loyalty Group," which has carried the Society's health and accident group insurance since 1936.

2. Q. What expenses are covered?

A. The policy will pay all reasonable charges necessarily incurred by an insured member of the Society, or by the insured eligible dependents, for medical, surgical, hospital, or registered nurse or trained attendant services, also for x-ray examinations and treatments, laboratory tests, anesthesia, drugs and medicines and all other therapeutic services and supplies, as the result of any one accident or because of all sickness resulting from one cause.

3. Q. Are all expenses paid by this policy?

A. No, the member is reimbursed for 80 per cent of the actual expense incurred as the result of illness or accident, excluding the first $500 of expense.

4. Q. If Blue Cross or other insurance pays a portion of the first $500 of expense, when would benefits start with this plan?

A. Benefits would start after $500 of expense had been incurred regardless of whether that $500 or any part of it, was paid by other insurance.

5. Q. How long are the benefits paid?

A. Until the member has incurred $5,000 of expense for each individual or dependent covered by the policy, or for a period of two years; whichever occurs first.

6. Q. What are the age limits of this policy?

A. A member, or a member's spouse, may be insured until age 70 and unmarried children may be insured until their 23rd birthday.

7. Q. Is the policy an individual or group form?

A. The State Medical Society has a Master Group Policy and each insured member is given an individual policy certificate.

8. Q. When will this coverage become effective?

A. The contract will become effective when 50 per cent of the eligible members of the Society have applied, as is customary in all group insurance. Each applicant will be notified of the effective date.

9. Q. Under what circumstances could the policy be terminated by the Company?

A. Only if all policies issued to members of the Society should be terminated on a renewal date, or an insured should cease to be a member of the Society, or cease to be actively engaged in medical occupation, or nonpyament of premium.

10. Q. Would a member or his dependent who was receiving treatment prior to and on the effective date of the policy be entitled to benefits?

A. No.

11. Q. Are there any geographical restrictions as to where expenses are incurred?

A. No—coverage is worldwide.

12. Q. What are the policy exclusions?

A. Expenses incidental to: private flying, any act of war, self-inflicted injuries, obstetrics, or resulting from an intercurrent pregnancy, military or naval service, confinement or care in any Federal or State hospital for which the member is not required to pay, any expenses covered by Workmen's Compensation.

13. Q. Are disabilities occurring to more than one member in a family at the same time covered?

A. Yes.

14. Q. Is a relapse or recurrent condition considered the same disability?

A. Yes, if the same condition recurs within six months of the termination of the expense for which payment has been made.

15. Q. Can members not covered by the Society's group accident and health policy obtain this coverage?

A. Yes, every member under age 70 is eligible.

16. Q. Where will claims be adjusted?

A. All business of the Company, including the adjustment of claims, will be transacted at 185 Church Street, New Haven, Connecticut.

THE COST OF THIS PLAN

	ANNUALLY	SEMI-ANNUALLY
Member only	$32.00	$16.50
Member and one dependent	60.00	30.50
Member and more than one dependent	75.00	38.00

A United Profession

A labor leader has said, "The future of our free society depends on the voluntary assumption of social obligations by the major elements within society." Voluntary prepayment medical care insurance in its fullest development can be one of the great forces in maintaining such freedom, for it ultimately could cover all illnesses and medical expense in the low income group and greatly lighten the burden of such expenses in other groups. The increased costs of adequate medical care today not only are due to increased living costs but to the costs of newer and more extensive methods in diagnosis and treatment. The actual costs of professional medical services in these spirals is relatively not great. Nevertheless, there remain heavy responsibilities for the medical profession in keeping the public informed of the values to be found in voluntary type insurance, in cooperating in the management and administration of such insurance, and in keeping itself always aware of the basic issues involved in the preservation of medical freedom.

In considering voluntary medical insurance as sponsored by a medical society of which a physician is a member, his first duty is to recognize the honesty of purpose of those of his brother physicians who so generously give time to its guidance. Once this is granted it should not be difficult to realize their heavy responsibilities in making decisions which determine policies, decisions which may, and often do, involve sums of money usually reckoned in terms of big business. He should know also that efficient machinery exists within their control for prompt action in problems which may involve personal relationships between himself, his patient, and the plan.

The rare "protest" resignation of a cooperating physician which is occasionally reported, appears on its face to be more suggestive of the wounded vanity of adolescence than the result of mature thinking. "Rugged individualism" may have its

virtues but it has no virtue in being an escape mechanism from the facing of realities which today threaten the freedom of the entire medical profession. A united profession for greater developments in voluntary medical insurance or else! It is as simple as that.

The Art Exhibit

From small beginnings the art exhibit at our Annual Meeting has grown to occupy an important place in that event. A "hobby" has been defined as an "occupation that is not one's main business," which will describe the interest of those who contribute their work to our art show. From the medical viewpoint, such direction of interest into other than main channels is occupational therapy at its best. Doctors in the Arts have a distinguished record in all fields as artists, collectors and critics. Some have reached highest eminence in both fields as did Tait McKenzie and Seymour Haden, to mention two largely within our own time. The appreciation of art as a study holds fine rewards for those who may not choose to risk brush or paint.

Each year we look forward with an increased anticipation to the art exhibit. It is our hope that the art committee fully realizes the indebtedness which the Society owes to them for their continued effort.

The Ill Effects of Immobilization

Anyone who has had experience with thrombosis and embolism knows that their occurrence after major accidents, or as postoperative or puerperal complications, often results not only in more or less circulatory disability in the legs, in the veins of which venous thrombosis is most common, but that in a small percentage of patients it causes one of the most unpredictable and distressing complications of childbirth, accident, or operation: sudden and often fatal pulmonary embolism. It was assumed for many years, no doubt correctly, that the situation was, in part at least, the result of the detrimental effect of bed-rest on the venous circulation of the lower extremities and, as a result of this view, some surgeons submitted their patients after major operations to bed exercises which were devised to overcome this handicap. The fact that these were never widely adopted does not prove that they were valueless, but suggests that they were not sufficiently efficient or that their supervised observance, especially in late years, was not practicable on account of the shortage of trained help. Nor must it be forgotten that there is also a hereditary factor which predisposes to thrombosis.

Of recent years it has become customary to get both operated patients and puerperal women out of bed very much earlier than was formerly the case. While it is true that among the aborigines, and even in some immigrant Europeans, mothers often got up and performed manual labor a few hours after childbirth, this was not regarded as sound practice, and it is doubtful that statistics covering circulatory complications in these patients were ever published. The present situation was encouraged by the shortage of hospital beds during the war, which cut down the period of hospitalization that was allowed, and was perhaps stimulated also by some of the early studies on the modification of metabolism by injury. At any rate, it is now customary, with apparently good results, to get most patients with acute illnesses, and even those with serious cardiac complaints, out of bed after a much shorter period of complete rest than was formerly considered desirable.

In addition to the groups of patients just described, there are others likely to be kept in bed for even longer periods either because of the supposed "equalizing" effect of rest on the circulation or because their condition is such that they are unable to be ambulant. Among the former group are patients with thyroid and rheumatic heart disease in whom it has been customary to order prolonged bed-rest, and in the latter are semiconscious or comatose patients or those with such diseases as paraplegia, advanced muscular dystrophies, cerebral hemorrhages and other completely incapacitating ailments. It is obvious that the rheumatics and thyroidics could move about in bed and are not immobilized to the extent that a paraplegic, for example, would be. In these chronically bedridden patients it was noted that bedsores, hypostatic or insufflation pneumonia, muscle weakness and stiffness, constipation and, at times, osteoporosis and nephrolithiasis occurred.

A recent study by Deitrick and his collaborators* throws some interesting light on the phenomena associated with prolonged immobilization and clearly shows that they are by no means all circulatory. By carefully controlled studies on human volunteers,

*Bull. New York Acad. Med. 24:364, 1948.

who were subject to periods of activity, of complete rest, and of oscillation in a special bed, they showed that some of the ills ascribed to immobilization, constipation for example, did not occur, and that the effect on vital capacity, maximum ventilation and speed of circulation was negligible. The influence on basal metabolism was minimal. On the other hand there was loss of weight due to atrophy of the leg muscles, there was definite calcium loss after the fifth week of immobilization, there was impaired control of the venous circulation of the legs, and some subjects complained bitterly of pain in the knees. By the use of the oscillating bed many of these effects were minimized, and it is evident that the results of the study point the way to improved management of patients with chronic illnesses in whom movement in bed is limited.

G. B.

Something to Vote About

American citizenship may be acquired in the delivery room or the courtroom, but it is fully achieved only in the daily realization of those privileges and duties that give man his rightful place in society. Yet when it comes to voting—the keystone of citizenship—Americans in the past have had a tragic apathy.

In 1948 there were approximately 96 million eligible voters in the United States. But in that year, only 49 million—about half of the eligible voters—cast ballots in the Presidential election! And the turnout at the polls has been decreasing! Such a record in America, where free elections protect the rights and liberties of the individual, is more threatening to our freedom than any threat from abroad.

In recent elections, according to the *Saturday Evening Post*,* the voters in leading countries exercised their right of franchise as follows:

Belgium	90 per cent
Italy	89 per cent
Great Britain	82 per cent
France	75 per cent
Japan	70 per cent
United States	51 per cent

Why are Americans so apathetic? Why do so many of us sit back and "let George do it?" Perhaps it isn't apathy. Perhaps it basically an unawareness of issues.

Japan had a new-found individual freedom when 70 per cent of its voters cast their ballots. France and Belgium had just dropped the Nazi yoke. England turned to Churchill after years of Socialist rule. Italy arose against Communist infiltration. People in those Nations really had something to vote about.

Americans have something to vote about, too. Daily the issues are growing more clearly defined. The world needs a strong, sure America—and only Americans can keep our Nation strong.

Our role is clear. Whatever path we want America to take, we citizens at the grass roots must make the choice. We must study the issues. We must decide. We must vote. And as good citizens, we must do everything in our power to see that others register and vote, too—because today we Americans, of all the peoples of the world, have something vital to vote about!

*January 12, 1952, pp. 10, 12

More About the National Health Service

From an Editorial, Bristish Medical Journal, February 9, 1952. No. 4753, p .312,3

"Sooner or later the Government will have to define its social policy more clearly. The idea behind the National Health Service was surely not that it should be free—for such an idea is in fact absurd—but that it should be available to all without a financial barrier between the sick and their treatment. There is little doubt that few can resist the temptation to get something apparently for nothing—especially out of the State. The introduction of charges in the Health Service—begun by the Labour Government—will, it may be argued, induce a greater sense of responsibility in those who use it and will lead to its being used more intelligently. Last year the people of this country spent, according to Mr. Gammans, £778m. on tobacco, £488m. on beer, £650m. on gambling, and £107m. on going to the cinema. In the face of this it is difficult to argue that Britons cannot afford token charges for certain medical services. To call such charges financial barriers to treatment is a misuse of language, though there are problems to which thought should be given—old age pensioners, for example, should be directly exempted from such charges. And doctors should not be employed as collectors. Nevertheless, and economic factors apart, it is surely time to re-examine the implications of a something-for-nothing policy—which to a large extent is the policy of the Welfare State. Some limits must be set to paternal government; a paternism that saps initiative and responsibility will bring in its train not health but sickness."

THE PURPOSES AND FUNCTIONS OF VOLUNTARY HEALTH AGENCIES

Allan J. Ryan, m.d., *Meriden*

The most important single factor in the development of research and educational programs for the control of those diseases, which have been the major causes of death and disability, has been the appearance and growth during the last half century of the great voluntary health agencies. Although the American Public Health Association was founded in 1872, it was not until 1904 that the National Tuberculosis Association was organized as the first of the voluntary associations devoted to the control of a single disease. At least fourteen national associations of this type have been organized since then.

A list of the names of these organizations with the years in which they were founded will indicate immediately to anyone familiar with modern medical progress, that they have been a powerful influence in this direction. The American Cancer Society and the American Social Hygiene Association were founded in 1913, The National Society For The Prevention Of Blindness in 1915, The American Hearing Society in 1919, The National Society For Crippled Children And Adults in 1921, The American Heart Association in 1922, The National Foundation For Infantile Paralysis in 1938, The American Diabetes Association in 1940, The National Multiple Sclerosis Society in 1946, The Arthritis And Rheumatism Foundation in 1948, The National Epilepsy League and The Cerebral Palsy Association Of America in 1949, and The American Leprosy Foundation and The National Association For Mental Health in 1950.

The broad objectives of these organizations may be summarized briefly in the following purposes: first, they seek to disseminate information regarding the nature and occurrence of the particular disease as widely as possible to stimulate interest in the problems of control which are presented. Second, they make either a limited or general appeal for funds to carry out a program of control. Third, they undertake a comprehensive program of public and professional education, designed to prevent the disease if possible, and to limit the extent of its ravages by promoting early detection and treatment. Fourth, they aid in the establishment of programs of research into the causes of the disease and improve methods of treatment. Fifth, they provide in varying degrees aid and comfort to those already suffering from the disease by direct subsidy of treatment or service through volunteer activity. Sixth, they seek, by direct action or by example, to encourage the spending of public monies either by the federal, state or local government, to enlarge the control program or to establish certain portions of it on a continuing basis.

The organizations which carry out these programs are typically headed by a national board of directors elected by the members. Under their directions, state, county and local divisions, committees and chapters undertake the field work of the organization, chiefly through the activity of volunteers. The number of full time paid personnel in all of these organizations is very small compared to the roster of those who donate their services, many on a practically full time basis. The administrative budgets are consequently small, averaging less than ten per cent of funds collected, assuring the utilization of the maximum amount for disease control.

Both physicians and lay people are eligible for membership in all of these organizations, although in some cases there are classifications of the membership which tend to favor medical control. Cooperation between the professional and non professional members has been the rule, however, and the success of this joint venture can be said to be characteristic of the development of these associations. This has gradually resulted in many organizations in equalization of lay and medical control of policies and administration.

Intensive campaigns of fund raising on a nationwide basis by mail, individual and group solicitation, benefits, coin boxes and by encouraging bequests have provided the funds to make these programs possible. The enthusiastic and untiring efforts of volunteers, many of whom have had personal experiences with the diseases they are seeking to control, have resulted in the raising of many millions of dollars. Recently a threat to the success of these accomplishments has been posed by the trend toward united or federated fund drives. Despite the fact that it has been demonstrated repeatedly that organizations raising large sums of money independently must inevitably accept less in the united drive,

From the Meriden Hospital Bulletin, October 1951

because its individual appeal is lost in the mass, many divisions or chapters of these voluntary health associations are joining such federations either voluntarily or under pressure. It is still too early to assess the ultimate effect of this development, but the immediate results in some of our largest cities have been devastating.

The achievements of the voluntary health associations are too varied and too numerous to be listed here in detail. They have made the people of this country conscious of the importance of preserving good health. The traditional social stigmas attached to certain diseases, particularly venereal, mental disease and cancer, have been largely removed, making a more effective control possible. Federal, state and local public health control measures, amounting in terms of funds expended to many times the money raised by the voluntary agencies, have been undertaken as a direct result of these associations' activities. Tuberculosis has moved from the first to sixth place in the list of causes of death in this country, considerably as the result of the efforts of The National Tuberculosis Association, to cite one of many possible specific examples.

"The voluntary health movement has had its fullest flowering in the United States. Nowhere else in the world has this type of service developed to such extent or in such variety. It is truly an extraordinary expression of the goodwill and the neighborliness of the American people, their generosity and their genius for organization." These words of Dr. Thomas Dublin, executive director of The National Health Council, indicate at once the unique achievement and the hope for the future. There has certainly been no flagging of interest on the part of the established organizations, and the number of new associations formed during the last five years exceeds that during any similar period. Present indications, therefore, augur for the continued development of the movement which has helped to make this nation the healthiest on earth.

Direct Enrollment Campaign Features Blue Cross Fifteenth Anniversary Celebration



Biggest Check in Connecticut, symbolizing Connecticut Blue Cross payments to local hospitals over the past 15 years, is displayed by George R. Willis, (left) Blue Cross treasurer, and Edward K. Warren, president of the Connecticut Hospital Association. It's all part of the Statewide celebration this month, marking the hospital plan's 15th anniversary. Highlight of the Blue Cross birthday-month is a Direct Enrollment membership offering for the benefit of those who are not eligible to join through payroll groups. For the first time, the Direct Enrollment age limit has been waived. Applications and information are available at Blue Cross area offices and all general hospitals.

PROGRESS IN CLINICAL MEDICINE

INDUSTRIAL MEDICINE AS A LEGITIMATE FIELD FOR THE GENERAL PRACTITIONER

JOHN F. KILGUS, JR., M.D., *Litchfield*

The Author. *Chief, Division of Health Services for State Employees, Connecticut Department of Health*

FROM the title of this paper, the writer is immediately confronted with the necessity of defining, first a General Practitioner, and second, Industrial Medicine. This would seem simple until one tries to put it on paper. For the first definition, I like best the definition suggested by the American Academy of General Practice Committee on hospitals; namely, "A General Practitioner is a legally qualified practitioner of medicine who does not limit his practice to a particular field of medicine or surgery. In his general capacity as a family physician and medical advisor, he may, however, devote particular attention to one or more special fields, recognizing at the same time the need for consulting with qualified specialists when the medical situation exceeds the capacity of his own training and experience." As for a suitable definition for Industrial Medicine, I have not been so fortunate as to find one already coined. Perhaps we may say that Industrial Medicine is general medicine in its broadest sense, as it applies to the care of the industrial worker. Industry may be defined as a trade. We think of it in such terms as the steel industry, the automobile industry, etc., in other words, it is an organized productive endeavor of some sort. We may even extend this to include business of any sort employing workers.

In a survey of the membership of the American Academy of General Practice, it is noted that 94 per cent of the members "see industrial cases." This seems at first glance a high percentage unless we think of industry in a broad sense. This same survey shows further that 20 per cent of these same A.A. G.P. members devote full time to "industrial practice."

Let us then consider what are the functions and duties of the "industrial physician." An editorial in the September 1951 issue of *Industrial Medicine* states—"The real industrial physician is directly identified with industry, and usually functions on its premises. Such a physician is imbued with the philosophy of constructive medicine and is conversant with the philosophies of industry, production and manpower. He is versed in the peculiar administrative requirements of this task, directs or understands industrial hygiene, maintains a preventive program, and is competent in the allied matters of safety engineering, employment, compensation and other forms of insurance. That which marks the industrial physician as such is that in addition to outstanding qualifications as a physician he moves with facility among machines, materials, manpower, products and processes, and program group enterprises."

What better ground work or training could a man have to fit him to meet these requirements than the training of a general practitioner? He first of all must be a skilled physician, skilled not in one or two fields, but skilled in the general field of medicine. His patients in industry are workers and they are people—the same kind of people he cares for in general practice. These people have problems—problems not entirely related to their occupation. A medical program in industry that does no more than treat occupational injury and disease is not worthy of the name. The successful industrial physician must treat the patient as a whole, not only that part of him that is engaged in industry. He must understand him, be sympathetic to his problems and worries. He must realize that a worker who is worried about a sick wife or child, or about an overdue mortgage cannot be an efficient worker. He must be prepared to counsel him, not as a worker, but as an individual with individual problems of

Remarks of Retiring President, Connecticut Chapter of the American Academy of General Practice, Wallingford, October 17, 1951

great complexity. He must treat soul as well as body. Who, but a general practitioner could successfully do this?

"The industrial physician has only one objective in his relation to workers, the maintenance of a work force sound in body and mind, capable of performing acceptable work, unharmed by any work process, and contentedly adjusted to work requirements and work environment." His brand of medicine must be preventive as well as curative. Here he enters the public health field which is closely allied to the industrial or occupational health field. He must be a teacher for nowhere are the opportunities for teaching good health practices more abundant than in a group of workers. Each patient who visits his clinic must leave a little wiser in matters of health and the care of his mind and body, than when he entered. He must know and think of these workers as his private patients. He must know these people as Joe, not merely the mechanic from the garage, and Mary, not just as the typist with the sprained wrist. He must be able to discern that Joe's real trouble is not the carbon monoxide he breathes in the garage, but a wife who is dying with cancer, and Mary's trouble is not just a lame wrist, but a fiancé in Korea.

Let us for a moment consider the day's work of an industrial physician, thinking as we enumerate his tasks, how well the general practitioner is qualified to perform them. We may begin with the pre-employment physical examination. This is not a process whereby only the supermen are sorted out for employment, but rather a preplacement examination. The physician tries to see the prospective employee as a whole; he notes his strength and his weakness; he sees his good points and his defects. He tries to fit this man or woman into the industrial picture from a physical and mental standpoint, just as the personnel officer does from the standpoint of qualifications for the job. He does not reject the man because his back is not strong enough to do the heavy lifting required of a truck driver, but recommends that he be given other employment of which he is physically and mentally suited. Some of our more progressive large industries with diversified activities pride themselves on being able to place almost every applicant, even the physically handicapped.

The pre-employment examination may be interrupted to treat an employee who has been burned. He does not merely apply vaseline gauze and a pressure bandage, but he inquires of Mike how he was burned. He learns that he put his paint pail into the furnace to burn it out and didn't get out of the way in time. The doctor gives him a little good advice on safety practices and later discusses the situation with the safety engineer and the supervisor.

The next patient may be a man who has reached his 70th birthday and is about to retire. This man feels that he has reached the end of the road, and nothing lies ahead. He must counsel him, as Dr. Stieglitz so aptly puts it—"A man must retire to—not from something." He must endeavor to convince him that there is much ahead of him even though it may not be wise for him to continue in his present occupation.

At this point a group of laboratory workers come in for periodic physical examinations, and their typhoid boosters. He calls one employee's attention to her poor teeth, and urges that she consult her dentist; another employee to his high blood pressure, and advises that he put himself under the care of his family physician. At no time must the industrial physician take over the functions of the private physician, nor trespass in his field. Those of us who have been in private practice appreciate this and act not to displace the family physician but to aid and assist him in every possible way.

An employee may come in asking for an aspirin for her headache. A little questioning as to the probable cause, frequency and duration of the headache is in order. A few more minutes may be consumed in having the nurse test the girl's eyes with the Keystone machine. Here a possible cause of her headaches may be discovered and she is urged to have her eyes examined by a competent ophthalmologist.

The x-ray technician calls the physician into the dark room to look at the wet film he has just taken. A complicated fracture is evident. This may well be an injury beyond the scope of the industrial physician's training and experience, and he makes arrangements for the injured employee to be taken to an orthopedic specialist where he may be given the best treatment possible. It is just as important for the industrial physician to be aware of his limitations as his capabilities, and he owes allegiance to his employer too; he must endeavor to get this man back to work in the shortest possible time, with the least permanent disability. He must be ever mindful that he is first of all a physician, and he is bound by the strict code of ethics which he may not violate for any cause.

The day's work is not done, for there are the records to be attended to. The physician's records in industry are extremely important, and must be

accurately kept. These records must be treated with the same confidence as the private physician treats like material. Only if the employee is confident of this will he really confide in the physician, and unless he does, the help he can hope to receive from the physician is limited. A mutual understanding concerning the confidential nature of medical records must be had between the industrial physician and management. This is not always an easy matter, and much time and patience must go into the education of the lay management concerning medical ethics.

In conclusion, let me say that I am convinced that no field of medicine offers a brighter future for a physician with a background of general practice than this ever broadening field of occupational medicine. Every true general practitioner, or to use the more intimate term, "family doctor's" real aim in life is to do all the good that he can. His is a busy life of service and his reward is often not material. His satisfaction is derived from a job well done and the knowledge that perhaps for many this world has been a little brighter, a little happier, just because of him. One of the few things I disliked about private practice was, that in order to live, I had to charge my patients for the things I did for them, for the care and advice I would so willingly have given them. In Industry one has the opportunity to give without the necessity of receiving from the patient more than his appreciation. Certainly no man has a better training and background for industrial practice than does the family doctor.

State Funds For Student Nurses

Because physicians are frequently asked to counsel young women regarding the choice of nursing as a career, the Connecticut State Nurses' Association wishes to call their attention to the fact that State funds are available to help those students who qualify in all respects for a nursing career but who do not have sufficient funds to meet the school expense.

Physicians are asked to urge such students to make application immediately, through the nursing school of their choice, since applications for assistance from this fund cannot be accepted after June 1, 1952.

Young women who apply for this assistance must have been residents of Connecticut for four years.

Information on State Approved Schools of Nursing can be secured from the Connecticut State Nurses' Association, 252 Asylum Street, Hartford.

RESOLUTION
Passed by the Board of Regents of the American College of Surgeons, December 3, 1951

Whereas there are existing American Boards for certification in general surgery and each of the surgical specialties; and

Whereas these American Boards, in their standards and in the application of such standards, have significantly contributed and continue to contribute to the elevation of the quality of care and treatment of the surgical patient to the highest level yet obtainable in American surgery; and

Whereas there can be no logical justification for the establishment of other certifying boards in the same professional fields; and

Whereas the International College of Surgeons has established certifying boards in general surgery and the surgical specialties; and

Whereas, in the opinion of the Board of Regents of the American College of Surgeons, the application of standards fixed by the boards of the International College of Surgeons is not in accordance with the generally accepted principles of education and training upon which competence in surgery is evaluated; and

Whereas most patients, in their selection of surgeons, are unable to distinguish between two standards for certification;

Therefore be it Resolved that the American College of Surgeons deplores the establishment of certifying boards other than those approved by the Advisory Board for Medical Specialties, and regards such actions as constituting a menace to present standards in the practice of surgery and to their further elevation; and

Be it Further Resolved that it is the sense of the Board of Regents of the American College of Surgeons that no Fellow of the American College of Surgeons should support, in any manner whatsoever, the establishment and perpetuation of certifying boards other than those approved by the Advisory Board for Medical Specialties, or support any organization which sponsors such other certifying boards; and

Be it Further Resolved that a copy of this resolution be sent to each Fellow of the American College of Surgeons and to each established American Board for certification in surgery and the surgical specialties.

THE PRESIDENT'S PAGE

At the February meeting of the Professional Policy Committee of CMS, Dr. Horton, the Director of Medical Services, presented a proposal for inhospital medical care as an additional benefit to be offered without increase in premium, subject to approval of the Board of Directors of CMS, the Insurance Commissioner of the State of Connecticut and the House of Delegates of the Connecticut State Medical Society. Briefly, as it will be presented elsewhere, the proposed provisions of the program are as follows:

(1) Payment to be made for the services of physicians to patients hospitalized for medical diagnoses.

(2) No payment to be made for medical care when payment is also made by CMS for surgical care.

(3) No payment to be made during the first three days of hospitalization.

(4) Payment to be made on a basis of $3 per day—begining with the fourth day of hospitalization and extending for twenty-one days during any one calendar year.

These proposals will be brought before the attention of the House of Delegates at our Annual Meeting in April. This widening of physician participation in CMS, I believe, is an important matter. The fees scheduled will be the subject of criticism and controversy. It should be emphasized that this is only a beginning, and on an exploratory basis, and as experience is gained the base will be widened further and the fee scheduled increased as soon as sound, financial balance can be obtained. There is danger that this present advance might be "killed off" by too much criticism and misunderstanding. It is to be recalled that financial disaster befell those other plans which ventured into too glib medical payments. CMS, in following its present procedure, is to be congratulated.

Brae Rafferty, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

CALL
ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1952 Annual Meeting of the House of Delegates will be held in the Auditorium of the Bulkeley High School, Hartford, commencing at 10 o'clock in the morning on Tuesday, April 29.

Brae Rafferty, President
Creighton Barker, Secretary

COUNCIL MEETING

A regular meeting of the Council was held on Thursday, February 21, at the Society's offices in New Haven. There were present: Drs. Bishop, Danaher, Fincke, Gettings, Gibson, Howard, Labensky, Parmelee, Rafferty, Root, Thoms, Tracy, Walker, Whalen, Gallivan, Barker. Absent: Drs. Couch, Gilman, Murdock, Phillips, Squillante, Ursone, Weld.

NOMINATING COMMITTEE

The Nominating Committee for 1952 presented its recommendations. These were discussed and, with minor changes, adopted by the Council for presentation to the House of Delegates at its meeting on April 29.

RENOMINATION OF DR. MURDOCK

In accordance with the permissive provisions of Article IX, Sec. 1, Par. 2 of the By-Laws, the Council nominated Thomas P. Murdock, Trustee of the American Medical Association, to be a member of the Council of the Society for the year 1952-53.

STUDY OF OUT-PATIENT CLINIC SUPPORT

A lengthy report from the Committee to Study Out-Patient Clinic Support had been distributed to the members of the Council with the agenda for this meeting. After discussion, it was agreed that the proposal made by the Committee to continue along the lines outlined in the report be approved and that the Committee may seek continued participation of the Connecticut Hospital Association and the Connecticut Cancer Society in the Committee's projects, and add personnel to the Committee.

REPORT OF COMMITTEE ON HOSPITALS

A progress report from the Committee on Hospitals was presented. The principal part of that report was a request for approval by the Council of a meeting of the Committee on Hospitals with the Blue Cross. (It was not stated who was to represent the Blue Cross, whether it would be the Board of Directors or the executive staff.) The purpose of this meeting would be to discuss the deletion of payments for services rendered by physician anesthetists and radiologists from the Blue Cross contract.

The Council questioned the propriety of such a conference at this time in view of the fact that the proposals to be made by the Committee on Hospitals might not reflect a generally held opinion on the part of the members of the State Medical Society and that no committee of the Society should enter into negotiations with an outside agency until it was quite certain that the policies proposed had been approved by the House of Delegates of the Society. To this end the Council suggested that the Committee on Hospitals discuss the proposal in the report of the Committee to be submitted to the House of Delegates on April 29 and introduce a resolution seeking official opinion of the House of Delegates in relation to the removal of payment for certain professional services from the Blue Cross contract.

The Council further suggested that the Committee on Hospitals confer with representatives of hospitals

in Connecticut. Since the change in the professional relationship of anesthetists and radiologists to hospitals will be a matter of decision on the part of the individual hospitals and it is only remotely a matter of concern to Connecticut Blue Cross because that agency only provides payment for these professional services and does not agree to provide the services themselves. It is to be noted that already Blue Cross does not make payment for the services of anesthetists in the Danbury, Greenwich, Middlesex, Milford, Norwalk, St. Joseph, St. Raphael, Sharon and Stamford Hospitals, and if similar arrangements are desirable by the anesthesiologists those arrangements should be a matter for negotiation with the individual hospitals and not with Blue Cross.

JUDICIAL COUNCIL OF THE AMA

The secretary reported that, as yet, no reply had been received from the Judicial Council of the AMA in response to a request for a ruling on matters contained in the report of the Special Committee to Inquire into Professional Practices at the New Haven Hospital, (Friedman Committee), which was submitted to the Judicial Council in May of 1951, as directed by vote of the House of Delegates. The secretary was instructed to communicate again with the Judicial Council asking if and when a ruling on the subject would be forthcoming.

DR. BRACELAND APPOINTED

The resignation of Dr. Daniel P. Griffin from the Society's Committee on Mental Health having been received and accepted, Dr. Francis J. Braceland, Hartford, was appointed to succeed Dr. Griffin.

BUILDING EXPANSION

A special committee appointed by the Chairman of the Council, consisting of Dr. Danaher, Dr. Gibson and Dr. Barker, Chairman, reported on preliminary inquiries concerning the possibility of adding to the Society's building to accommodate additional activities if advisable. No conclusions were reached and the committee was directed to continue its exploration of the subject.

1952 CLINICAL CONGRESS

The 1952 Clinical Congress was discussed and it was stated that the Committee on Postgraduate Education had tentatively agreed to have the Congress as directed by the Council at its meeting on January 17 and to shorten the duration from three days to two days and lower the registration fee from $4-$6, to $3 for members and $5 for non members.

CONNECTICUT HEALTH LEAGUE

Luther K. Musselman, New Haven; John W. Buckley, Bridgeport; Wilson F. Smith, Hartford, were appointed official delegates from the Society to the Connecticut Health League. Dr. Musselman is currently serving as vice-president of the League.

STUDENT MEMBERS

The following were elected to student membership to the Society.

Don R. Heacock, Staffordville
Howard University Medical School—Class of 1954
Pre-Med: Colby College
Parent: Don R. Heacock

William P. Keefe, West Hartford
University of Maryland—Class of 1955
Pre-Med: Holy Cross College
Parent: George G. Keefe, M.D.

John A. Nagle, Stamford
Jefferson Medical College—Class of 1955
Pre-Med: Fordham University
Parent: Harold E. Nagle

Carnes Weeks, Jr., Woodbury
University of Virginia—Class of 1953
Pre-Med: Yale University
Parent: Carnes Weeks, M.D.

AMERICAN MEDICAL EDUCATION FOUNDATION

The secretary reported the status of the American Medical Education Foundation campaign in Connecticut as of February 20.

Total pledged or contributed—$5,701.

Number of contributors and pledgors—131.

Number indicating direct payment to their medical schools—55.

Cash transmitted to AMEF—$4,546.

County breakdown (including those contributing directly to their medical schools):

Hartford County	56	Litchfield County	13
New Haven County	46	Middlesex County	12
Fairfield County	33	Windham County	9
New London County	14	Tolland County	3
		Total	186

Representation in the House of Delegates

The By-Laws of the Society provide that each county association is entitled to one delegate in the House of Delegates for each thirty-five members in

the association or fraction thereof based on the membership as of December 31 of each year. According to this, the quota of delegates from the county associations who should attend the Annual Meeting of the House of Delegates that will be held in Hartford, April 29 and the Semi-Annual Meeting in December is as follows:

COUNTY	MEMBERSHIP DECEMBER 31, 1951	OFFICIAL DELEGATES
Fairfield	696	20
Hartford	820	24
Litchfield	116	4
Middlesex	96	3
New Haven	767	22
New London	155	5
Tolland	16	1
Windham	63	2

Organize Connecticut Society of Board Obstetricians and Gynecologists



Dr. Louis F. Middlebrook, Hartford, secretary-treasurer of the recently organized Connecticut Society of American Board Obstetricians and Gynecologists, outlines the organization's articles of incorporation for Dr. Joseph H. Howard, Bridgeport, standing, right, and Dr. James R. Miller, Hartford, seated. The picture was taken at a meeting in Hartford February 13.

Meetings Held

March 6—Public Health Committee, Executive Committee
Clinical Congress Committee
Committee on Medical Care of Veterans

March 11—Medical Examining Board

March 12—Medical Examining Board

March 15—Committee to Study Maternal Mortality and Morbidity

March 20—County Officers Conference

March 26—Sub-Committee on Infant Mortality
Cancer Detection Committee

March 27—Medical Examining Board
Committee on Foods, Drugs, Cosmetics and Devices

March 31—Committee on Cooperation with Yale School of Medicine

New Society of Obstetricians and Gynecologists

Organization of the Connecticut Society of American Board Obstetricians and Gynecologists was announced recently by Carl E. Johnson, New Haven, first president of the new Society.

John M. Freiheit, Waterbury, is president-elect of the organization and Louis F. Middlebrook, Hartford, secretary-treasurer.

The first regular meeting of the Society will be held at the New Haven Lawn Club, Thursday, April 17, at 5:30 P. M. Robert A. Kimbrough, Jr., professor of gynecology and obstetrics at the Graduate School of Medicine, University of Pennsylvania, will present a paper titled "Carcinoma of the Endometrium—Etiology, Treatment and End Results." Representing the American Board of Obstetrics and Gynecology, Dr. Kimbrough will also present greetings of the Board to members of the new Society. Membership includes the 78 Connecticut physicians certified by the Board.

Plans to organize the new Society were initiated late in 1951 under the leadership of Hartwell G. Thompson, Hartford. The group was formally organized and officers were elected early this year and on February 13 a meeting was held in Hartford to adopt by-laws and sign the articles of incorporation.

AMERICAN MEDICAL EDUCATION FOUNDATION

FUND-RAISING COMMITTEE

CONNECTICUT STATE MEDICAL SOCIETY

Physicians who have contributed in the current campaign and those who have indicated they are contributing directly to their medical schools as of March 12

FAIRFIELD COUNTY

Meyer Abrahams, New Canaan
John D. Booth, Danbury
Philip R. Carroll, Jr., Bridgeport
Rector T. Davol, Greenwich
Ralph H. Edson, Shelton
J. Benton Egee, Newtown
C. Louis Fincke, Stamford
Wesley F. Fitzpatrick, Norwalk
Harold Genvert, Norwalk
Grace V. Gorham, Norwalk
R. Warren Hall, Trumbull
George W. Hebard, New Canaan
Robert B. Hiden, New Canaan
Joseph H. Howard, Bridgeport
A. Boswell James, Bridgeport
Marjorie S. Knauth, Wilton
Neil F. Lebhar, Westport
Paul Lengyel, Bridgeport
R. Harold Lockhart, Bridgeport
Frederick A. Patterson, Norwalk
Robert A. Northrop, Norwalk
John S. Poczabut, Stamford
Harold Ribner, Bridgeport
Michael V. Sciortino, Bridgeport
Howard P. Serrell, Greenwich
Milton Sheiman, Bridgeport
Samuel C. Sheiman, Bridgeport
Luther M. Strayer, Bridgeport
George L. Tunick, Greenwich
Ellwood C. Weise, Bridgeport
Francis B. Woodford, Ridgefield
Robert H. Wyatt, Stamford
Isidore Yasser, Bridgeport
John B. Zielinski, Bridgeport

HARTFORD COUNTY

Preston N. Barton, Terryville
Edmund Beizer, Hartford
Charles T. Bingham, Rocky Hill
Marvin B. Day, Hartford
Ralph E. Durkee, Hartford
William J. Doerr, Hartford
Ralph M. Filson, West Hartford
John N. Gallivan, East Hartford
Forrest D. Gibson, Hartford
Leroy C. Grau, Hartford
Dwight Griswold, Hartford
George M. Gura, Southington
Jack Gurwitz, Hartford
Francis W. Helfrick, Manchester
Harold A. Howard, Wethersfield
Glover E. Howe, Hartford
Joseph F. Jenovese, Hartford
Robert H. Karotkin, Hartford
Robert R. Keeney, Manchester
Joseph Klein, Hartford
William J. Lahey, Hartford
John C. Leonard, Hartford
Howard J. Lockward, Manchester
Raymond D. Lublin, East Hartford
George A. F. Lundberg, Manchester
Morris M. Mancoll, Hartford
Sidney R. McPherson, Hartford
James R. Miller, West Hartford
Joseph A. Mlynarski, New Britain
Philip J. Moorad, New Britain
Michael J. Morrissey, Hartford
Harriett E. Northrup, West Hartford
Robert H. Osmond, Hartford
William H. Pomeroy, Poquonock
John V. Prignano, Manchester
Renato A. Ricca, Glastonbury
John C. Rowley, West Hartford
Charles T. Schechtman, New Britain
William B. Scoville, Hartford
Warren B. Silliman, Windsor
E. Myles Standish, Hartford
Hilda C. Standish, West Hartford
James H. Standish, Hartford
Theodore W. Steege, Hartford
William F. Storms, Wethersfield
William H. Upson, Suffield
Euen VanKleeck, Hartford
N. William Wawro, Hartford
Stanley B. Weld, Hartford
Gideon R. Wells, Hartford
Benjamin B. Whitcomb, Hartford
Benjamin V. White, Hartford
Harold B. Woodward, Bristol
Edmond R. Zaglio, Manchester
Norman Zeldis, Hartford

LITCHFIELD COUNTY

Thomas J. Danaher, Torrington
William G. H. Dobbs, Torrington
George L. Cushman, North Woodbury
G. Robert Downie, Winsted
Louis E. Garston, Torrington
Harry B. Hanchett, Torrington
Arthur H. Jackson, Washington
William B. Lyons, Thomaston
Edwin G. Reade, Watertown
Daniel P. Samson, Thomaston
James T. Smith, Winsted
Edward H. Wray, Jr., Litchfield

MIDDLESEX COUNTY

Harriet Bixby, Mansfield Depot
G. Mansfield Craig, Middletown
Clair B. Crampton, Middletown
Richard F. Grant, Cromwell
Carl C. Harvey, Middletown
Walter R. James, Essex
Louis O. LaBella, Middletown
Christie E. McLeod, Middletown
V. Gerard Ryan, Portland
Archibald W. Thomson, Middletown
Vincent J. Vinci, Middletown

NEW HAVEN COUNTY

Edward P. Allen, New Haven
Creighton Barker, New Haven
Courtney C. Bishop, New Haven
Samuel P. W. Black, New Haven
Eugene M. Blake, New Haven
Dana L. Blanchard, Branford
George Blumer, San Marino, Calif.
Joseph J. Bowen, Jr., Waterbury
Eugene B. Brody, New Haven
John A. Chasnoff, West Haven
Thomas Cottiero, Waterbury
Hermann S. Cutler, New Haven
Arthur B. Dayton, New Haven
Clyde L. Deming, New Haven
Meredith M. Dickinson, Watertown
Theodore S. Evans, New Haven
William Finkelstein, Waterbury
Joseph A. Fiorito, New Haven
William I. H. Fischer, Milford
Russell V. Fuldner, New Haven
Henry A. Geib, Milford
Arthur J. Geiger, New Haven
William J. Goade, Boston, Mass.
Morris Goldstein, New Haven
William M. Good, Waterbury
Morris A. Hankin, New Haven
John E. Harty, Waterbury
Albert E. Herrmann, Waterbury
Maurice M. Hillman, New Haven
Clayton H. Hitchins, New Haven
Mary L. James, North Haven
Robert H. Jordan, New Haven
LeMoyne C. Kelly, Waterbury
John J. Kennedy, Jr., Windsor Locks
Henry Krochmal, Meriden
Maxwell Lear, New Haven
Jerome A. L'Heureux, Meriden
J. Wister Meigs, New Haven
Henry Merriman, Waterbury
Thomas P. Murdock, Meriden
Richard Newman, New Haven
Edward W. Oxnard, Cheshire
Gioacchino S. Parrella, Milford
John P. Riesman, New Haven
Milo P. Rindge, Madison
Wilder Tileston, New Haven
Leo L. Tylec, Naugatuck
J. Alfred Wilson, Meriden

NEW LONDON COUNTY

Henry A. Archambault, Taftville
Frederick C. Barrett, Jewett City
Louis Guss, Norwich
Frederick B. Hartman, New London
Morris E. Katz, Norwich
Winfield O. Kelley, Norwich
Martin L. O'Neill, Jewett City
David G. Rousseau, Taftville
Richard M. Starr, New London
John W. Suplicki, Norwich
Paul Sutton, Groton

TOLLAND COUNTY

Wendelin G. Luckner, Stafford Springs Elliott H. Metcalf, Rockville

WINDHAM COUNTY

Sawyer E. Medbury, Willimantic
Richard V. Newcombe, Willimantic
Edward J. Ottenheimer, Windham
Karl T. Phillips, Putnam
Brae Rafferty, Willimantic
William M. Shepard, Putnam
Nathan Spector, Willimantic
John A. Woodworth, Moosup

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
John E. Flaherty, Rockville
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

New Hartford Emergency Plan Has Many Calls

Approximately 200 calls were received through the new Hartford emergency medical call system during its first thirty days of operation.

The system, inaugurated early in February, is sponsored by the Hartford County Medical Association in cooperation with the Hartford Medical Society.

In announcing the number of calls for the system's first month of operation, Dr. James R. Cullen, Association president, emphasized the importance of public cooperation in using the service only for genuine emergencies. Study of the first 175 calls disclosed that a number of them could have been avoided with proper forethought.

The service was instrumental, however, in promptly meeting many real emergencies. Accident cases included a man who had severed the tops of several fingers, a factory worker whose eye was pierced by a steel splinter, and a woman who had mistakenly swallowed poison.

The study also disclosed that a surprising number of persons do not have a family physician and the public announcement stressed the importance of making such selection as a first step toward being prepared for emergencies.

Fourth Annual PR Conference Proceedings Published

Proceedings of the American Medical Association's Fourth Annual Conference on Medical Public Relations, held in Los Angeles last December, have been published in a 64 page booklet.

The booklet contains a digest of the principal activities of the two day meeting, including addresses by John W. Cline, AMA president, Louis H. Bauer, president-elect, and a number of State medical and public relations leaders; panel discussions on the costs of sickness, cooperation with allied groups, and public relations goals for State and county medical associations. Also included are three reports on opinion surveys and the psychological factors in medical care.

Copies of the booklet may be obtained through the Public Relations Section of the State Medical Society.

Public Opinion Survey Gets Trial Run in Illinois

Lawrence W. Rember, director of field service for the Public Relations Department of the American Medical Association, recently announced results of an experimental public opinion survey conducted in Decatur, Illinois.

Thirty basic questions concerning medical care, its availability and quality, hospital care, the costs of medical, hospital and drug services and opinions about medical organizations were asked in 300 interviews among the 66,000 inhabitants of the area.

Ninety-one per cent of those interviewed said they had a family physician and 88 per cent said they could obtain medical services at any time. When asked about costs, 43 per cent said hospital bills were too high, 44 per cent that drug bills were excessive and 29 per cent thought surgical fees high.

Surgical care rated highest in regard to quality. Medical care was voted excellent by 38 per cent, good by 53 per cent and fair by nine per cent. Eighty-one per cent of families interviewed had some form of hospitalization insurance and 84 per cent of these were satisfied with their policies.

Fifty-five per cent said they had not heard of their county medical association or did not know enough about it to express an opinion. Eighty-nine per cent of those expressing an opinion said they thought favorably of the association.

Ninety-four per cent of the group said they liked doctors and 91 per cent felt their physicians had a personal interest in them.

A summary of the survey indicates a high percentage of favorable responses, with percentages of disapproval ranging from six to 29 per cent. A five-point program to meet problems disclosed by the survey has been initiated by the Macon County Medical Association.

Auxiliary Plans PR Booklet

The Public Relations Committee of the Woman's Auxiliary is planning publication of a booklet concerning community service programs.

The booklet will accent the value of information concerning the activities and accomplishments of medical organizations and will serve as a guide in public relations activities for Auxiliary members.

Mrs. Morton Arnold, Willimantic, chairman of the committee, has announced that plans are being considered to mail the booklet with notices of the Auxiliary's annual meeting, to be held in Hartford Wednesday, April 30.

County Programs Featured at Officers' Conference

Reports concerning the public relations activities of medical associations in Fairfield, Hartford, and Middlesex Counties were a feature of the Conference of County Medical Association Officers Thursday afternoon, March 20, in New Haven.

Oliver L. Stringfield, president of the Fairfield County Medical Association, spoke on the topic "New Ventures in Fairfield County" and Burdette J. Buck, chairman of the Hartford County Medical Association's Public Relations Committee, presented a report titled "Hartford County on the Move."

"Middlesex County Looks Ahead" was the title of a talk by Harry C. Knight, chairman of the Public Relations Committee of the Middlesex County Medical Association.

At the evening session, Mr. Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, Oakland, California, was principal speaker. Mr. Watterson spoke on the topic, "Association Activities That Win Membership Participation."

Statement of Policy

Connecticut Association of Pathologists

1. The hospital pathologist is a practitioner of medicine and is subject to the same ethics as all other medical practitioners.

2. Appointment or dismissal of the pathologist should be approved by the committee of the Medical Staff which recommends appointment or dismissal or all other members of the Staff.

3. The pathologist should be a member of the full attending staff and director of the Division of Pathology. He should hold equal status in the Staff Organization with the directors of the other divisions of the Staff. The pathologist, as director of the Division of Pathology, should be a member of the Medical Board or its equivalent.

4. The laboratory budget should be under the control of the pathologist within the limits of income derived by this Department.

5. The hospital should provide the pathologist with at least semiannual periodic financial statements of the operations of his department in order that he may operate his department within its income, on the one hand, and that he may be appraised of what sums of money are available for expansion of service, on the other hand.

6. The contractual arrangement with the hospital should permit the pathologist to participate financially in the fruits of his own endeavors and should assure himself of an income comparable to that of other medical specialists of comparable training requirements in his community.

7. The manner in which the pathologist conducts his department should be subject to review and constructive criticism by an appropriate committee including key members of the medical administrative organizations. The pathologist should meet with this committee at appropriate intervals.

NEWS FROM WASHINGTON

House Refuses to Pass Universal Military Training Bill

The House March 4, voted 236-162 to recommit the Universal Military Training bill to committee for additional study. This action has the probable effect of killing the bill for the remainder of this session of Congress. Prior to the House vote a confusing parliamentary situation prevailed. At one point the House voted to replace the committee bill, HR5904, with a substitute, HR6860 by Rep. Brownson, providing for a two year high school ROTC program. The House later reversed its position on the Brownson substitute and voted recommittal of HR5904.

EMIC Financing Not Fifty-Fifty

Based on the bill's provision that the Secretary of the Treasury shall pay to each State which has a plan approved an amount equal to the expenditures made by the State it was reported that the federal government and the States would equally bear the cost of both the EMIC program and the proposed general hospitalization program. We are now informed by the drafters of the legislation that provisions dealing with financing are interpreted by them to mean that the federal government would fully reimburse the States for all funds expended in conducting these two programs.

New Senate Legislation

S2705—Social Security Amendments. By Messrs. Lehman of New York, Murray of Montana, Magnuson of Washington and Humphrey of Minnesota, February 21. To extend and improve the old age and survivors insurance system, to provide permanent and total disability insurance and rehabilitation benefits. Referred to the Committee on Finance.

Comment: Bill would (a) extend social security benefits to an additional eleven million persons, (b) increase benefits approximately 35 per cent, (c) raise the taxable base from $3,600 to $6,000 on which is predicated the contributions of employees and employers, (d) increase both the employee's and the employer's contribution to four per cent (each) by the year 1961—the self-employed would contribute 5¼ per cent by 1961, (e) add a compulsory program of permanent and total disability benefits and a cash sickness benefit program (temporary disability), and (f) finance a broad rehabilitation program for disabled persons covered by social security.

According to testimony given on the 1953 FSA Appropriation Bill, approximately 75 per cent of the population (workers and their dependents) are now covered by social security. Under the terms of this bill, adding eleven million persons to the rolls, approximately 83 per cent of the population would be covered. The main additions are farm owners and workers, additional household domestics, members of the armed forces, and certain groups of government employees. Self employed physicians, lawyers, and certain other professional persons are not included.

The suggested new program for permanent and total disability provides benefit payments to those unable "to engage in any substantially gainful activities by reason of any medically determinable physical or mental impairment or blindness." A six-month waiting period is required before benefits are to be paid. An additional program of temporary disability, which in the bill is designated as "cash sickness benefits," would provide benefits to a person unable "to perform his most recent, customary or reasonably similar work by reason of any medically determinable illness, injury or other impairment." This waiting period is only one week.

Disabled persons, before becoming eligible for benefits under the permanent and total disability program or the cash sickness program, would be required to submit themselves for medical examination. Medical examinations could be performed at existing federal facilities or by private physicians, clinics, hospitals or other medical facilities as determined by the Administrator of the FSA. Examination costs would be paid from the Social Security trust fund. The Administrator of the FSA would require periodic re-examination for disability insurance, and refusal of the claimant to appear and cooperate would cause a forfeiture of benefits. The Administrator is given the right to waive further

examination after two years of total disability, if he feels that recovery seems remote.

Rehabilitation of disabled covered persons and their dependents would be financed from the Social Security trust fund. Existing State rehabilitation agencies would be paid the total cost of their programs and there would be no requirement that the State governments match federal funds. If this program becomes law it would at least partially replace the need for the existing rehabilitation program of the FSA, for which Congress appropriates approximately $21.5 million annually. Simultaneous with this bill's introduction four identical bills were introduced in the House (House authors were: Dingell, Roosevelt, Jackson and Mitchell).

S2714—Industrial Safety. By Mr. Murray, of Montana, February 21. To provide for assistance to State agencies administering labor laws in their efforts to promote, establish, and maintain safe work places and practices in industry, thereby reducing human suffering and financial loss and increasing production through safeguarding available manpower. Referred to the Committee on Labor and Public Welfare.

Comment: An unnamed sum of money would be provided by the federal government so that the Secretary of the Department of Labor could allocate funds based upon a formula to the several States for industrial safety programs. States to be eligible would be required to meet standards set forth in the bill. The formula would be based on population, number of wage earners, special industrial hazards, number of workers afforded protection, the cost of State administration and the financial needs of the States. No State could receive more than ¾ of its total expenditures from the federal government. A minimum allotment for each State would not be less than $15,000.

Action

S2552—Female Military Medical Personnel. The Senate Armed Services Committee February 27, favorably reported this bill to the Senate floor. The bill's provisions would authorize the appointment of qualified women as physicians and technical specialists in the medical services of the Armed Forces and in the reserve components on the same basis as men.

VA Reports It Has 475 Vacancies for Physicians

The Veterans Administration has informed Congress that 475 medical posts, for which funds have been appropriated, remain unfilled because of inability to procure physicians. Dr. C. F. Bayer, chairman of a special board, listed these VA vacancies in testimony before Senate Committee on Expenditures in the Executive Department as: neuropsychiatrists, 140; general medicine, 113; surgery and subspecialties, 106; tuberculosis, 54; radiologists, 18; pathologists, 24; administration, 11; and physical medicine, 9. Dr. Bayer said there was a shortage of 300 nurses for general medicine; 192 for tuberculosis and 186 for NP hospitals. He described the situation as "abnormal."

Hospital Fees Push Up Medical Care Costs

Bureau of Labor Statistics in Labor Department reports a 3 per cent increase in the national average cost of medical care and drugs for the fourth quarter of 1951, in contrast to a 1 per cent rise during the third quarter. Of the various items and services surveyed by the government, hospital rates showed an increase of 6.8 per cent. Close behind were premiums for group hospitalization (Blue Cross) programs, up 5.8 per cent.

BIS gave these figures on other fees: physicians generally, up 2.3 per cent; general practitioners, up 2.5 per cent; surgeons and specialists, up 1 per cent; dentists, up 1.2 per cent; prescription drugs, down 0.1 per cent.

Narcotics Control Proposed Through Banks, Insurance Firms, Ship Owners

Rep. Adolph J. Sabath (D-Illinois) proposes to make observance of narcotic import restrictions the responsibility of banks, insurance companies and ship and airplane owners, and to deny U. S. funds or trade concessions to foreign countries which refuse to cooperate in eliminating excess production. His bill (HR6543) would:

1. Forbid banks, insurance companies and ship and airplane owners to participate in any transaction concerned with illegal narcotics. First offense by insurance companies or carriers would result in a $50,000 mandatory fine, the second a $100,000 mandatory fine. If convicted a third time, the com-

panies would be denied the right to operate in the United States. Banks would pay a $50,000 fine for each offense. Management would be expected to make a "reasonable effort" to determine whether transactions or shipments involve narcotics "which are not to be used for purposes approved by the Secretary of the Treasury."

2. Require that governments of India, Iran, Pakistan, Thailand, Turkey, Yugoslavia and Mexico agree to a limitation of production of narcotic drugs. Governments of the United Kingdom, France, Italy, Switzerland, the Netherlands and Belgium would be required to sign a similar agreement limiting the manufacture of narcotic drugs. A country refusing to cooperate would be denied benefits under "any act providing economic or other aid to foreign countries, or trade preferential treatments."

Marihuana is classified as a narcotic for purposes of the bill, but barbiturates are not mentioned.

Second Regional Program Established for "Blue Babies"

A second regional program to facilitate treatment of "blue babies" and children with other congenital heart malformations has been established to serve Arizona, Idaho, Nevada, Alaska and Hawaii. The California Department of Health, which already has a similar program for the children of that State, will act as clearing house, referring cases to selected hospitals and practicing specialists. U. S. Children's Bureau has allocated $36,201 for operation of the program the remainder of this fiscal year, through next June. The Bureau said that because of limited funds, for the time being, preference will be given to children who show evidence of congenital heart lesions amenable to surgery. It is estimated that about 35 children will benefit. The budget provides for inpatient care for both diagnosis and treatment, physicians' fees, necessary special nursing and auxiliary service and convalescence. A similar service already is in operation in Connecticut to serve children from that State and Rhode Island.

Changes in Operating Rooms to Cut Down Static Electricity Recommended

Three U. S. Bureau of Mines scientists, reporting on a 2½ year study of static electricity in hospital operating suites, state that in order to reduce the hazard of anesthetic explosion to the minimum, "major changes are needed in most hospitals." Their 64 page report is an outgrowth of numerous tests in 78 operating rooms, 22 delivery rooms and 16 hospital corridors. Studies were made in 14 hospitals. The scientists were an electrical engineer, a physical chemist and a physical science aide. In their report, they state:

"There is probably no combination of equipment and personnel activity anywhere more liable to produce casual, dangerous charges of static electrcity than that found at present in the anesthetizing areas of most hospitals."

The report notes that remedies have been suggested over the years (*Journal of the AMA* is cited as early as May 17, 1924) but that "it appears, however, that very few hospitals have made a studied and continued effort to apply the remedies effectively." The authors suggest that while waiting for major changes and for the appearance of proper material and equipment, hospitals can initiate a number of effective and simple improvements. Among their recommendations are:

1. Conductive rubber mattresses, pads and pillows should be substituted for the ordinary variety as soon as they are available. (Conductive substances pass on the electricity before a dangerous charge can be built up.) 2. Conductive shoes should be worn by all personnel. 3. Suitable conductive breathing tubes, masks and bags should be installled on anesthesia machines. 4. Stools with smooth, rounded feet and bare-metal tops are the most satisfactory. 5. Outer garments of wool, silk or synthetics such as nylon, rayon or orlon should be prohibited in anesthetizing locations. 6. A suitable measuring instrument should be installed in convenient and safe place for testing conductivity of shoes of all personnel entering anesthetizing area.

For 20 years or more experts of the Bureau of Mines have been studying the dangers of static electricity in an effort to promote safety in mines. Copies of the report may be obtained by writing to U. S. Bureau of Mines, 4800 Forbes Street, Pittsburgh 13, Pa.

Chest X-rays

Since its inception several years ago by USPHS, community-wide chest x-raying campaigns have uncovered nearly 50,000 previously undetected cases of tuberculosis (2 million more chests will be x-rayed in coming fiscal year) . . . even after five years

of Hill-Burton program, nation is still short 874,000 hospital beds, according to compilation of data furnished USPHS by States and territories . . . cancer training grants to medical schools have "enthusiastic" indorsement of AMA, subcommittee was informed . . . water fluoridation was described as "most remarkable preventive measure developed in the history of dentistry."

Doctors' National Group Will Campaign for Taft

Taft campaign headquarters in Washington has announced establishment of a national committee of physicians to support the Ohio Senator's bid for Republican nomination. A dental group with same goal reportedly is being formed. Two well known figures in medicine head new committee—Chicago's Ernest E. Irons and Boston's Frank Lahey, chairman and vice-chairman, respectively. AMA's House of Delegates is well represented on its roster—Drs. Howard Schriver (Ohio), Elmer Hess (Pa.), Leland S. McKittrick (Mass.), George A. Unfug (Colo.) and others. Working for Taft in New Hampshire's primary last month was a special committee headed by Drs. B. Read Lewin, of Claremont, and Stanley W. Yudicky, of Manchester. But Wisconsin's primary, coming later, will provide the Big Battle—as far as organized medicine is concerned—with Taft arrayed against AMA's arch enemy, Governor Warren.

Drs. Mider and Wegman Named to Key Posts in Capital

Two separate appointments, involving physicians distinguished in different fields, have been disclosed. Dr. G. Burroughs Mider, professor of cancer research and coordinator of cancer teaching at University of Rochester, is to be scientific director of National Cancer Institute. Newly created education and training division in Pan American Sanitary Bureau will be headed by Dr. Myron E. Wegman, now chief of pediatrics department at Louisiana State University. "In his new post, Dr. Mider will be responsible for intramural research of National Cancer Institute," commented Surgeon General Leonard A. Scheele. "Already one of the world's leading centers of cancer research, the Institute proposes to undertake new research along several lines of approach in the Clinical Center of National Institutes of Health."

Estimated 3,833,000 Births in 1951 Would Be New Mark

According to provisional figures of U. S. Public Health Service, number of births in 1951 was 3,833,000, which is 15,000 above 1947 when an all time record was established. Total is more than 200,000 in excess of figure for 1950. Annual birth rate for 1951, based on registered births exclusively, climbed to 24.5 per thousand population, an increase of 4.3 per cent over previous year. For 15th consecutive year there was a decline in infant mortality rate, latest figure on which is 28.8 per thousand live births. In 1940 it was 47.4 and in 1930 64.8. Preliminary estimates indicate a 1951 over all death rate of 9.7 per thousand, representing no change from previous year. Mortality level has remained below 10.0 for four consecutive years, according to USPHS.

National Advisory Committee Cautions Hospitals on Selecting Residents

National Advisory Committee to Selective Service advises hospitals to attempt to select their residents for 1952-53 in the reverse order of their priority under the Doctor-Draft law, with none chosen from Priority I "except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital." The Committee also reiterates that information on registrants, submitted for the purpose of reopening their cases, must come from the chairman in the State in which the individual is engaged in his professional activities and must be addressed to the man's local Selective Service Board. The National Committee explained that information on the registrant should come from the State chairman rather than the local committee where he is located to avoid "putting one hospital out of line" with the other hospitals in the affected city.

Facts About AMA Dues for 1952

The following information on membership dues for the American Medical Association for 1952 has been compiled by the office of the secretary of the American Medical Association.

1. American Medical Association membership dues for 1952 are $25.

2. Fellowship dues for 1952 have been abolished.

3. American Medical Association membership dues are levied on "active" members of the Association. A member of a constituent association who holds the degree of Doctor of Medicine or Bachelor of Medicine and is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and has paid his American Medical Association dues, subject to the provisions of the By-Laws, is an "active" member of the Association.

4. American Medical Association membership dues are payable through the component county medical society or the constituent state or territorial medical association, depending on the method adopted locally.

5. Commissioned medical officers of the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration and the Indian Service, who have been nominated by their Chief Medical Director, may become Service Fellows on approval of the Judicial Council. Service Fellows need not be members of the component county or constituent state or territorial associations or the American Medical Association. They do not receive any publication of the American Medical Association except by personal subscription. If a local medical society regulation permits, a Service Fellow may elect to become an active member of a component and constituent association and the American Medical Association, in which case he would pay the same membership dues as any other active member and receive a subscription to *The Journal of the American Medical Association.*

6. An active member of the American Medical Association may be excused from the payment of American Medical Association membership dues when it is deemed advisable by the Board of Trustees, provided that he is partially or wholly excused from the payment of dues by his component society and constituent association.

The following may be excused in accordance with this provision: (a) members for whom the payment of dues would constitute a financial hardship as determined by their local medical societies; (b) members in actual training but not more than five years after graduation from medical school; (c) members who have retired from active practice; (d) members who have reached the age of 70, on request, and starting January 1 following the 70th birthday, and (e) members who are called to active duty with the armed forces (exemption begins July 1 or January 1 following entrance on active duty). The last two categories are excused from AMA dues regardless of local dues exemptions.

7. Active members of the American Medical Association are not excused from the payment of American Medical Association membership dues by virtue of their classification by their local societies as "honorary" members or because they are excused from the payment of local and state dues. Active members may be excused from the payment of American Medical Association membership dues only under the provision described in paragraph 6 above.

8. American Medical Association membership dues include subscription to *The Journal of the American Medical Association.* Active members of the Association who are excused from the payment of dues will not receive *The Journal* except by personal subscription at the regular subscription rate of $15 a year.

9. Members may substitute one of the special journals published by the Association for *The Journal* to which they are entitled as members.

10. A member of the American Medical Association who joins the Association on or after July 1 will pay membership dues for that year of $12.50 instead of the full $25 membership dues.

11. An active member is delinquent if his dues are not paid by June 1 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after the notice of his delinquency has been mailed by the secretary of the American Medical Association to his last known address.

12. Members of the American Medical Association who have been dropped from the Membership Roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to the one year of delinquency.

13. The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000), or fraction thereof, active members of the American Medical Association as recorded in the office of the Secretary of the American Medical Association on December 1 of each year.

THE DOCTOR'S OFFICE

Marie Fakkel, M.D. announces the opening of an office for the practice of medicine and surgery at 1187 Sumner Street, Stamford.

Thomas McLean Healy, M.D. announces the opening of an office for the practice of surgery at 249 Main Street, Manchester.

Robert P. McKeogh, M.D. announces the opening of an office for the practice of gynecology and obstetrics at 93 Elm Avenue, Quincy, Mass.

Theodore W. Steege, M.D. announced his retirement from private practice on February 16, 1952 to accept the position of assistant director of Hartford Hospital. Dr. Steege is turning over his practice of internal medicine and cardiology to Dr. Franklin B. Watters, 85 Jefferson Street, Hartford.

Charles M. Suttles, M.D. and Benjamin J. Lord, Jr., M.D. announce their association in the practice of internal medicine at 16 Franklin Street, Norwich.

The Hospital Standardization Program

The appointments to the Joint Commission on Accreditation of Hospitals and the various organizations which they represent, have been announced:

American College of Physicians
- Alexander M. Burgess, M.D., Providence, Rhode Island
- William S. Middleton, M.D., Madison, Wisconsin
- LeRoy H. Sloan, M.D., Chicago, Illinois

American College of Surgeons
- Arthur W. Allen, M.D., Boston, Massachusetts
- Evarts A. Graham, M.D., St. Louis, Missouri
- Newell W. Philpott, M.D., Montreal, Quebec

American Hospital Association
- Edwin L. Crosby, M.D., Baltimore, Maryland
- Judge Milton George, Morden, Manitoba
- John H. Hatfield, Philadelphia, Pennsylvania
- Right Reverend Monsignor J. J. Healy, Little Rock, Arkansas
- A. J. J. Rourke, M.D., San Francisco, California
- Charles F. Wilinsky, M.D., Boston, Massachusetts

American Medical Association
- Gunnar Gunderson, M.D., LaCrosse, Wisconsin
- L. W. Larson, M.D., Bismarck, North Dakota
- Julian P. Price, M.D., Florence, South Carolina
- Stanley A. Truman, M.D., Oakland, California
- Herman G. Weiskotten, M.D., Skaneateles, New York
- Rolland J. Whitacre, M.D., East Cleveland, Ohio

Canadian Medical Association
- E. K. Lyon, M.D., Leamington, Ontario
- (A. D. Kelly, M.D., Toronto, Ontario, Alternate)

The Joint Commission held its first meeting on Saturday and Sunday, December 15 and 16, at the Drake Hotel in Chicago. Further details concerning the plan for the Joint Commission on Accreditation of Hospitals have been published in the Bulletin of the American College of Surgeons, 40 East Erie Street, Chicago 11.

New England Health Institute Executive Committee Appointed

Dr. Stanley H. Osborn, Commissioner of Health, has appointed an executive committee from the health department staff to supervise plans for the 18th New England Health Institute to be held at the University of Connecticut at Storrs, on June 18, 19 and 20.

Chairman of the committee is Mr. Chester S. Bowers, West Hartford. Committee members are Dr. Henry P. Talbot, Dr. Martha L. Clifford, and Dr. Albert S. Gray, West Hartford; Dr. Elias J. Marsh, North Haven; and Dr. Friend Lee Mickle, Wethersfield.

The executive committee will assist the many persons and agencies throughout New England interested in making this conference the outstanding event of the year so that everyone will be familiar with the New Efforts for Health Improvement which is the theme of the institute. This 18th New England Health Institute will be unique in many ways. It comes at a time when the facilities at the University of Connecticut will be available because the dates fall between the spring and summer sessions.

A large area of conference space this year will be devoted to scientific displays by official and voluntary health and commercial organizations.

The executive committee has appointed seventeen sub-committees so that every phase of health will be covered and new programs established throughout the country will be considered. Since five New England States health departments, and two schools of public health, are among the sponsoring agencies from throughout New England, a record attendance is expected.

MILITARY AFFAIRS

COMMITTES ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Induction of Priority I Doctors for August and September Again Delayed

The Department of Defense has requested the Selective Service System to further postpone until May, 1952 the induction of 485 Priority I physicians originally scheduled for August and September, 1951.

The Department of Defense emphasized that this delay is possible because at the present time there are sufficient numbers of Priority I type Reserve Officers to meet military requirements for individual calls to active service. The primary source of these Reserve Officers has been Priority I registrants who accepted reserve commissions. If, in the future, the number of registrants who accept reserve commissions should fail to meet requirements, it will become necessary to make up shortages through induction.

Priority I medical registrants are those who participated as students in the Army Specialized Training Program or similar programs administered by the Navy, and those persons who were deferred from service during World War II to attend medical school and who have served less than 90 days in the Armed Forces, the Coast Guard, to the United States Public Health Service subsequent to the completion of or release from the programs or courses of instruction.

Latest Figures Released on Draft-Vulnerable Doctors

Selective Service headquarters has compiled its monthly fact sheet, based on information supplied by the several States, on special registrants in medicine, dentistry and veterinary medicine. As of January 31, Priority I medical registrants totaled 10,785, of whom 1,094 were classified I-A and subject to induction. Nearly one-fourth (2,545) held Reserve commisssions but were not on active duty; 3,078 were in uniform; 1,550 were in the II-A professional deferment category; 2,107 were deferred as IV-F's. As for Priority I dentists, registrants totaled 3,928, with only 620 remaining in the I-A induction pool. On military duty were 1,252; 983 others held Reserve commissions; 279 were on II-A deferment; 575 were in IV-F. Of 1,799 veterinarians in I, 561 were in II-A deferred status, 486 held commissions, 328 were in I-A, 216 in IV-F and 119 were on active military duty.

Blood Priorities System in War and Peace Adopted

Weeks of hard work by a special study committee has produced a report on blood collecting and allocations which was promulgated in March as official policy by Charles E. Wilson, director of Defense Mobilization. Enforcement of the plan for development of this single National Blood Program now becomes responsibility of ODM's Health Resources Advisory (Rusk) Committee. It was a special subcommittee, headed by Dr. G. D. Cummings, of Michigan Department of Health, that formulated the program, principal features of which are: (1) Military, civil defense and normal peacetime blood needs will be served and donors will be solicited for the whole, rather than for its parts; (2) role of Red Cross as collecting agency for defense needs and collaborator with Federal Civil Defense Administration in setting up a plasma reserve is defined; (3) in allocation of whole blood, military requirements receive first priority and civilian second, with provisions made for assigning remainder to be processed as plasma and blood derivatives to meet immediate and reserve needs; (4) total reserves of plasma, derivatives and extenders shall be subject to reallocation by President in event of enemy action.

Armed forces participated in fashioning the new "unified" system, yet they are still publicizing the "Armed Forces Blood Donor Program" and leading public to believe that all blood donated (79,194 pints for week ended March 2) is ticketed for administration to servicemen.

FROM OUR EXCHANGES

Chloromycetin, firmly established as a very effective antibiotic of low toxicity with a wide antibacterial range, has one drawback, because of its extreme bitterness it must be administered in capsules and some patients, both children and adults, have difficulty in swallowing capsules. *(Bull. New England Medical Center*, 13.6.) At the New England Medical Center in Boston Finn and Kane tried out Chloromycetin palmitate, an ester which contains 57.6 per cent of chloromycetin. A palatable liquid preparation was prepared and it was shown by studies in 35 patients that the drug was set free and absorbed satisfactorily in the intestine even in patients with deficient pancreatic lipase. Detectable blood levels were obtained within one half hour and satisfactory levels were maintained longer than with the original drug. A cumulative effect was obtained when the ester was administered every 4 to 6 hours and there were no gastrointestinal disturbances.

* * * *

The medical schools now are insisting on greater breadth of education for applicants and are urging that undue emphasis shall not be placed upon the sciences, according to Ernest C. Marriner, dean of Colby College faculty in the *Journal of the Maine Medical Association* (42.9). What is wanted for medical schools are students with character, personality, industry, resourcefulness and judgment, plus first class minds.

* * * *

In a paper entitled "Iatrogenic Diseases" *(North Carolina Med. Jour.*, 12.11) Nicholson stresses the importance of exhaustive study in order to arrive at a correct diagnosis. The literal interpretation of his subject title is "the morbid state created by the physician." An incorrect diagnosis resulting in mistreatment of the patient is responsible, says the author, for the greater number of iatrogenic diseases. Diagnosis of an illness frequently calls for procedures which may endanger the life of the patient. The final court of decision as to what diagnostic procedures should be carried out rests with the physician. After a diagnosis is made the physician should weigh the beneficial results of any form of therapy against the harmful effects of the same therapy, taking into consideration the primary disease from which the patient is suffering. The physician may even create a new disease if it is sufficiently serious. An etiologic classification of iatrogenic diseases is furnished, in addition to the history of those cases seen at Duke Hospital under the various categories.

* * * *

In "Adrenocortical Function in Pernicious Anemia" by Strauss and Brokau *(N. E. Jour. Med.*, 245.21) the authors from clinical observation list the following manifestations of Addison's disease of the suprarenal capsule which may occur in Addisonian pernicious anemia in relapse but appear to be relatively uncommon in other forms of anemia: asthenia, arterial hypotension; pigmentation of the skin and mucous membranes; anorexia, nausea, vomiting, diarrhea; apathy and other mental changes; inability to consume sodium chloride; inability rapidly to excrete water load; nocturnal polyuria and fixation of urinary specific gravity; diminished glomerular filtration of serum nonprotein nitrogen; flat oral glucose tolerance curve; absence of fall in number of circulating eosinophils after injection of adrenocorticotropic hormone; and diminished urinary excretions of 17-ketosteroids. The authors conclude that the occurrence of numerous manifestations of Addison's disease of the suprarenal capsule or Addisonian pernicious anemia in relapse suggests that functional adrenocortical insufficiency may be present in certain cases of this condition.

* * * *

Pernicious anemia in old age is, according to Ivan V. Basylewycz *(R. I. Med. Jour.*, 34.12), more common in old people than is generally recognized. This disease in the aged is distinguished by a rather atypical, protracted and latent course. Usually the hyperchromic, macrocytic anemia with a megaloblastic type of blood formation, is moderate or mild and may be absent for a long time before becoming evident. The extra-anemic facets include neurological manifestations due to the lesions of the posterior or lateral columns, peripheral plexi and nerves, mental disorders, and diverse cardiovascular abnormalities. Disorders of the digestive system often play a subordinate part in the clinical picture.

Liver treatment should be carried out in all doubtful cases. The beneficial effects of liver therapy in the early stages of the disease are usually self evident.

* * * *

Clyde S. Roof presents an instructive discussion of the pros and cons of State medicine under the title, "The Parallel History of the American and British Medical Profession." *(Cincinnati Jour. of Med.*, 32.11). His conclusion is that "we must hold out for complete freedom until (1) the American public has had a first-hand view of socialism; (2) the American farmer has had a chance to talk to the British farmer (who knows the pangs of securing a permit for the slaughter of a lamb); (3) labor finds that it can turn no more to a friendly government for undue help."

Dr. Roof draws an interesting parallel around the early history of State medicine in England and what is going on in the United States at the present time. It is a good summary of the subject.

* * * *

George F. Lull ("Leeches to Antibiotics," *Jour. of Iowa State Med. Soc.*, 41.12) calls attention to the fact that the American Medical Association was worrying about medical education one hundred years ago and that "we are still worrying about it today—only the particular problem has changed." In 1851 there were only a few good medical schools and the struggle to raise the standards of medical education was just beginning.

A hundred years later there is, in the opinion of Dr. Lull, very little wrong with the quality of our medical schools but there is something very wrong with their finances. The socializers who within recent years have risen to plague us are in favor as usual of an act of Congress to dole out needed funds for this glamorous project. There is a temptation to accept this "easy money," forgetting that eventually we shall pay the price in a loss of freedom in medical education. The temptation is only increased by the minor successes of all efforts to raise funds from private sources (only 0.003 per cent of the doctors in the nation made a contribution in 1951 to the appeal of the AMA in favor of the medical schools).

Obviously there has been a deterioration in the last century in the doctor-patient relationship. A number of causes have contributed to this result. For one thing the modern doctor handles more patients than was formerly the case and spends less time with the individual patient. Back in 1851 every doctor was a family doctor who answered calls day and night and was intimately acquainted with the family problems. Today nurses and other aids have assumed many of the time-consuming duties that were formerly handled by the physician. The changes in the arts of medical practice from day to day have been almost imperceptible but they have been constant and in most instances they have been implicit in an expanding medical science. These changes have had the effect of apparently magnifying the costs of sickness. It should be added, however, that the cost of medical care has not soared as far or as fast as has the general cost of living.

If we study the cost of medical care from the angle of dollars and cents alone the average family spends no more—and perhaps less—on a percentage basis than they did half a century ago. Today the sick get a lot for their money. Seventy-five years ago all that the doctor had to offer a patient with acute appendicitis was a hotwater bag and a prayer. To be sure he charged only a dollar for the visit but measured in results it was an extravagant fee. In 1951 such a patient practically never dies and is sent home cured in a few days.

So far the best answer found to the problem of the increased cost of sickness care is found in various forms of voluntary health insurance. It is in this area too that we find our best answer to the socializer. The physician best serves himself and his self-respecting clients by promoting in every community such types of insurance. A duty that the doctor should accept as a good citizen is not only to vote at election time but to encourage others to vote for those candidates who have a decent respect for the freedoms of the individual citizen. The true strength of a nation is found in an independent and self respecting citizenry—and nowhere else.

* * * *

Suits for malpractice are discussed in an editorial in *Medical Annals of the District of Columbia* (20.11). The editor quite properly calls attention to the fact that "anybody can sue anybody for anything and cause loss of time and money and unwelcome publicity." However, if certain principles are observed the number of such suits can be reduced to a minimum. The principles that are enunciated are three:

1. Sufficient knowledge and skill. The knowledge and skill must equal that possessed by the average

doctor in the community in which the doctor is practicing, or of a like community in size and education. The doctor should recognize his limitations and seek advice from other doctors when his limitations are reached. Experimentation on his patients must be avoided. The doctor's practice must conform with recognized methods of diagnosis and treatment.

2. Due diligence. Neglect of the use of x-ray and other recognized laboratory tests would show a lack of due diligence. The doctor must keep himself informed at all times regarding the condition of the patient and he must see his patient often enough to insure this contingency. The doctor must vary his medication according to the exigencies of the case.

3. Best judgment. This principle requires that the doctor must not prescribe for a patient if the doctor is under the influence of alcohol or other drug, or if the doctor's health is such that clear thinking is interfered with.

It is probable that suits against doctors are not entirely disadvantageous. However, the editorial points out that we should try to reduce the number of malpractice suits.

* * * *

"The Management of Critical (Massive) Gastroduodenal Hemorrhage" (White et al, *Med. Annals of D. C.*, 20.11) is the subject of an interesting discussion. In the first place the authors prefer the term "critical" to "massive" as more descriptive of the existing situation. The medical and surgical treatment of this complication, with the present concept of treatment, should be the joint responsibility of the internist and the surgeon. A sharp line cannot be drawn between those cases that we may expect to recover under purely medical treatment and those who should submit to surgery. Briefly outlined are the principles of treatment. (1) Multiple transfusions are mandatory and arterial transfusion may be necessary. (2) Patients over 45 years of age have a higher mortality rate with critical hemorrhage than those below that age. (3) If repeated transfusions are not followed by cessation of the bleeding as determined by blood pressure and blood examinations, operation is indicated. (4) Shock is not a contraindication to operation if ample blood for transfusion is available. (5) Gastric resection is the operation of choice in gross ulcer. (6) Ligation may suffice in the small necrotic type of ulcer.

Banthine in the treatment of duodenal ulcers (Holoubek et al, *New Orleans Med. & Surg. Jour.*, 104.5) is an effective antispasmotic in the treatment of duodenal ulcers according to the authors. A dose of 50 mgm. every six hours with a bland diet and milk between meals usually affords relief. The cessation of the drug is necessary in a few patients because of unpleasant side effects. The use of banthine does not usually require hospitalization. The usual indications for surgical interference in duodenal ulcer remain unchanged.

* * * *

Accident prevention as a community health problem and as an obligation of the practising physician is presented in a persuasive manner by John E. Gordon (*Jour. of Mich. State Med. Soc.*, 50.11). Accidents as causes of death and disability are among the more important conditions in medical practice, particularly in childhood and with elderly people. Accidents to a material extent are preventable conditions. Adequate control of the chief class, that of home accidents, is only to be brought about by the activity of the medical profession.

The medical profession shows a manifest interest in immunization against diphtheria and in many other preventive measures. It is sometimes forgotten that preventive activities in private practice extend measurably past a concern with communicable disease. The author makes a plea for a logical approach to this problem so that there is an understanding of its size, the time during which it has been active, and a conclusion as to whether it is increasing or regressing in importance. The order of importance of the following grouping of accidents comes as a matter of surprise to many of us. These groups are as follows: (1) home accidents; (2) motor vehicles; (3) accidents occurring in public places; and (4) accidents of industry. Few would place the home as the most dangerous place in which to live, but from the standpoint of accidents such is the fact.

The above classification marks accidents as a community problem. The limitation of accidents consequently is a responsibility of community organization, in which medicine is invariably included. Probably the only approach to the home accident group is through the practising medical profession, along with aid from organized public health facilities of the community.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. F. Erwin Tracy, Middletown
President-Elect, Mrs. Barnett Freedman, New Haven
First Vice-President, Mrs. Ralph Ogden, West Hartford
Second Vice-President, Mrs. Dewey Katz, Hartford
Recording Secretary, Mrs. Arthur H. Jackson, Washington
Corresponding Secretary, Mrs. Harry C. Knight, Middletown
Treasurer, Mrs. William V. Wener, Norwich

State News

ANNUAL MEETING

The 8th Annual Meeting of the Woman's Auxiliary to the Connecticut State Medical Society will be held at the Hartford Golf Club on April 30. Luncheon will be served at noon. Perrin H. Long, professor of medicine, State University of New York, will address the meeting and show slides on the subject, "Length of Life." He is a nationally known investigator of the sulfa drugs and antibiotics.

To tie in with the Connecticut Medical Society's Art Exhibit at Bulkeley High School which the Auxiliary co-sponsors, Mrs. David Waskowitz of New Britain, a member artist, will paint the "Beginning of a Portrait—an Impression," with a running commentary. Her subject will be an Auxiliary member registered for the meeting whose name will be drawn by the Art Chairman, Mrs. N. Marinaro.

Mrs. Howard Root, a past president of the Massachusetts State Auiliary, now chairman of the National Revisions Committee, will provide a summary of national news pertinent to the Auxiliary.

ART EXHIBIT

We welcome F. W. Roberts of New Haven as successor to Robert Hansell of Greenwich, former president of the Physicians Art Association, who has left Connecticut.

A committee meeting of county art chairmen, together with Dr. Roberts and Mrs. Nicholas A. Marinaro of Hartford, State art chairman, was held in Hartford in March. A meeting will be called in April to draw up final plans for the exhibit. If you have not yet contacted your county art chairman about your exhibit, please do so immediately. Extra entry blanks are available from her.

The Art Exhibit will be held at Bulkeley High School, Hartford, April 29, 30 and May 1.

Obituaries

We regret to announce the loss of three of our members during the past year. We know that the Auxiliaries in which they had membership will be the poorer for their absence.

Mrs. Sinclair Levine of West Hartford
Mrs. Marvin Scarborough of New Haven
Mrs. Herbert Flynn of Mansfield Depot

County News

HARTFORD

The Annual Meeting of our Auxiliary was held at the Hartford Club on April 1. Dr. Francis J. Braceland, psychiatrist-in-chief at the Institute of Living, was the speaker. His subject was "Emotional Maturity."

As part of our Civilian Defense program, individual members have been working as volunteers at the Blood Bank and assisting in Home Nursing courses.

MIDDLESEX

The County's Semi-Annual Meeting convened on March 5 in Bengston-Wood Hall of Middlesex Hospital. Harold S. Barrett of the Connecticut State Department of Health spoke on the effect and precautions to be taken following an A bomb explosion. He prefaced his talk with the showing of the film, "You Can Beat the A Bomb."

The Annual Meeting will be held April 24 at Monte Green Inn, Middletown.

NEW HAVEN

An "Open House" for prospective nursing students will be held April 29 at the New Haven Medical Association Library, 364 Whitney Avenue, New Haven. Students of all secondary schools throughout the county who are interested in nursing will be given an opportunity to meet the Directors

of Nursing and faculty members, together with three student nurses from the six nursing schools in the county. The Dean of Girls from each of the secondary schools will also be present. The meeting is intended to acquaint all prospective nursing students with the teaching programs and facilities offered by the various county nursing schools. A film depicting the life of a student nurse will be shown. Co-chairmen in charge of the program are: Mrs. Stanley Boguniecki of Meriden and Mrs. Joseph D'Esopo of Hamden.

Auxilliary President's Message

"Why a Woman's Auxiliary to the American Medical Association?" "What does the Woman's Auxiliary do?" These questions are frequently asked of me and of other members of our organization. These are good questions and ones that I find challenging, particularly as we are trying to add 10,000 new members this year. I shall try to answer these questions as simply as I can.

In 1923, 28 years ago, the Board of Trustees of the AMA decided that a Woman's Auxiliary should be organized to promote the sale of *Hygeia* (now *Today's Health).* Subsequently, various State Medical Societies asked for the formation of State Auxiliaries; Connecticut's Auxiliary was organized in 1944 at Bridgeport.

Since we are primarily an Auxiliary to the AMA we should have a clear and definite understanding of the function of our parent organization and how it carries on its work. The AMA has as its objective the promotion of the science and art of medicine and the betterment of public health. It is a physician's organization existing to serve the physician and the general public.

Now for the Woman's Auxiliary to the AMA: It assists the AMA in its program for the advancement of medicine and public health; it coordinates and advises the activities of state and county Auxiliaries; and it promotes mutual understanding among physicians' families. In carrying out the above stated purposes it also promotes interest in health education, community health programs, rural health and civilian defense.

One of the major projects of the Auxiliary is to promote the circulation of *Today's Health*, a magazine which makes authentic health information available to the lay public.

The Auxiliary publishes a Bulletin which keeps local societies informed on national policies and projects. Also our State Auxiliary publishes a Bulletin. (We expect to change the name of our State Bulletin before the next issue.)

National Auxiliary conventions are held annually at the same time and place as the convention of the AMA. Each State is allowed a presidential delegate and a delegate for each 100 active members of the National Auxiliary in each State. This year the national convention will be held in Chicago June 9-13 at the Conrad Hilton Hotel. We hope to have our full quota of delegates present. Our membership totals about 1,100 members.

Working together for health* in our State is the privilege of each of the members of the Woman's Auxiliary to the Connecticut State Medical Society.

Mrs. F. Erwin Tracy

*National slogan for the Woman's Auxiliary to the AMA

NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL
477 First Avenue, New York 16, N. Y.

SEMINAR IN INTERNAL MEDICINE
8 weeks, full-time. April 14 through June 6, 1952
The seminar is composed of thirteen part-time courses in the various medical specialties (Acute and Chronic Diseases of the Chest, Allergy, Arthritis and Allied Rheumatic Disorders, Cardiology, Clinical Electrocardiography, Clinical Hematology, Diseases of the Liver and Biliary Tract, Endocrinology, Gastroenterology, Nephritis and Hypertension, Normal and Pathological Physiology; Functional and Chemical Aspects, Peripheral Vascular Diseases, Problems in Diagnosis).

These courses may be taken individually or concurrently

SEMINAR ON THE REHABILITATION OF CHILDREN
5 days, full-time. May 19 through 23, 1952
This course, particularly for pediatricians, is designed to give a picture, through lectures, demonstrations, clinics and conferences, of the organization, administration, integration, equipment, theory and practice of a pediatric rehabilitation service.

REVIEW OF DERMATOLOGICAL HISTOPATHOLOGY
Given At
The Skin and Cancer Unit of University Hospital
5 days, full-time. May 5 through 9, 1952

SYMPOSIUM ON DERMATOLOGY AND SYPHILOLOGY
(FOR DERMATOLOGISTS)
5 days, full-time. May 19 through 23, 1952

For application and information about these and other courses, address:
Office of the Dean, Post-Graduate Medical School
(A Unit of the New York University-Bellevue Medical Center)

Sage-Allen of Hartford
TELEPHONE
4-8771

SPECIAL NOTICES

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

The medical conferences of the Connecticut Veterans Administration Medical Society will be held during April 1952 at 3:30 P. M. on the dates listed below, at 95 Pearl Street, Hartford.

April 3

Sydney Selesnick, M.D., gastroenterologist, Veterans Administration Hospital, Newington

Pancreatic Disorder

April 17

Miriam Liberson, M.D., radiologist, Veterans Home and Hospital, Rocky Hill

Soft Tissue Calcification in Cord Lesions

April 24

Harold A. Lear, M.D., clinical assistant, Mt. Sinai and McCook Memorial Hospitals, Hartford

Common Urological Problems

YALE MEDICAL SCHOOL

On April 9 Dr. Cecil Drinker, former professor of physiology at the Harvard School of Public Health, will give an address on the "Lymph Drainage of the Lungs and Pleura." The program at the final meeting of the academic year on May 14, will be devoted to presentations of outstanding work carried out by students in the School of Medicine.

HEART SYMPOSIUM

Thursday, April 10, 1952, St. Mary's Hospital

Presented by Waterbury Heart Association, Inc., and St. Mary's Hospital at the hospital.

10:45 I—"Progress and Prospects in Rheumatic Fever"

George M. Wheatley, M.D., New York; Third Vice-President, Metropolitan Life Insurance Co.; formerly, chairman, Council on Rheumatic Fever

I—"Hypertension in the Aged"

Alexander M. Burgess, M.D., Providence, Rhode Island; Regent, American College of Physicians; Area Consultant, Veterans Administration; formerly, Chief of the Medical Services, Rhode Island General Hospital

III—"The Mechanism of Auricular Fibrillation and Flutter"

David Scherf, M.D., New York City; Associate Professor of Medicine, New York Medical College; co-author "Boyd & Scherf Cardiology"

1:00 Lunch at Hospital

2:30 Clinics, Question and Answer period

INSTITUTE OF LIVING CONFERENCES

The Eighteenth Annual Series of Conference Talks at the Institute of Living has been announced. Four lectures comprise the 1952 course. The first on "Main Causes of Difficulties Met With In Psychotherapy" was given by Dr. Gregory Zilboorg on March 25. The other talks include: Dr. Howard Scott Liddell, speaking on "Experimental Neuroses" on April 8; Dr. Lawrence S. Kubie, speaking on "Problem of Insight" on April 22; Dr. Elvin V. Semrad, speaking on "Psychotherapy of Psychoses" on April 29.

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

The Spring meeting of the Association of Connecticut Tumor Clinics will be held at the Greenwich Hospital on Tuesday, April 15, 1952 at 4:00 P. M. Details of the program will be announced at a later date.

Robert Tennant, M.D., Secretary

CONNECTICUT TB ASSOCIATION

The Connecticut Tuberculosis Association will hold its semi-annual meeting on April 17 at Gaylord Farm Sanatorium, Wallingford. The program and budget of the State Association will be presented at that time. There will be an opportunity to see the facilities of the sanatorium, particularly the new infirmary.

MICHAEL REESE HOSPITAL POSTGRADUATE SCHOOL

The Michael Reese Hospital Postgraduate School is offering a one week course in "Surgery—Indications, Pre- and Postoperative Care," from April 14 to April 18. Clinical and didactic material in this fulltime course will be presented by members of the Department of Surgery and cooperating departments. The course is designed for the practicing physician who wishes to keep abreast of curernt trends in surgery.

The Michael Reese Hospital Postgraduate School is offering a one week course in "Clinical Dermatology—Refresher Course in Diseases of the Skin for General Practitioners." This fulltime, intensive course will meet from April 21 to April 25. Clinics and lectures will be conducted by the members of the Department of Dermatology and Syphilology.

The Michael Reese Hospital Postgraduate School will be offering a two week course in "Diseases of the Endocrines—Physiology and Diagnostic Methods." This fulltime, intensive course will meet from April 28 to May 9, and will be under the direction of Dr. Rachmiel Levine, director, Department of Metabolic and Endocrine Research. Basic principles will be presented with a review of recent advances in the field. The course is designed for clinical application.

The Michael Reese Hospital Postgraduate School will be offering a two week course in "Recent Advances in Internal Medicine," from May 12 to May 24. This fulltime, intensive course encompasses a systematic review of recent advances in the various branches of internal medicine. The clinical and didactic material will be presented by members of the Department of Internal Medicine, other Clinical Departments and of the Division of Laboratories and Research.

The Michael Reese Hospital Postgraduate School is offering a one week course in "Recent Advances in Pediatrics—Diagnostic and Therapeutic Measures," from May 26 to May 31. Recent advances in pediatrics, including the presentation of clinical as well as didactic material. For the pediatrician and other physicians who limit their practice largely to children. The course will be presented by the Department of Pediatrics and cooperating departments. For further information on any of the above courses address: Dr. Samuel Soskin, dean, 29th Street and Ellis Avenue, Chicago 16, Illinois.

AMERICAN CONGRESS OF PHYSICAL MEDICINE

The Spring Session of the Eastern Section of the American Congress of Physical Medicine is to be held at the State Veterans Home and Hospital—Hospital for Chronic Illness, Rocky Hill, Connecticut, on Saturday, May 3, 1952 from 10:30 A. M. to 5:00 P. M. Luncheon will be served at the hospital at 11:30 A. M. Dinner and evening meeting will be held at the Hartford Club, with a social hour at 6:30 P. M., dinner at 7:15 P. M.

Morning Session

Visit to the Department of Physical Medicine and Rehabilitation at the hospital.

Afternoon Session

Evaluation Clinic, Department of Physical Medicine and Rehabilitation.

"Medicolegal Aspects of Industrial Injuries"
Samuel Sherman, M D, Pittsburgh, Pennsylvania

"The Scapulo-Humeral Angle—An Aid in the Diagnosis and Prognosis of the Stiff Painful Shoulder"
Harold Lefkoe, M.D., Philadelphia, Pennsylvania

"Mechanics of the Feet"
Allen S. Russek, M.D., New York City

"The Physical Aspects of Radiations"
Lewis Dickar, M.D., Brooklyn, New York

"Ultrasonic Therapy."
H. J. Behrend, M.D., New York City

"Serum Neuritis"
Arthur L. Watkins, M.D., Boston, Massachusetts

Evening Session

"What Is New With the Korean Casualty"
Lt. Col. John H. Kuitert, MC, Washington, D. C.

Luncheon is $1 and dinner is $4.50. Reservations for luncheon and dinner should be made in advance by contacting Dr. John C. Allen, Hartford Hospital, Hartford. For further information contact any member of the committee: Dr. Nila K. Covalt, State Veterans Home and Hospital, Rocky Hill, Chairman.

Dr. Thomas Hines, Grace-New Haven Hospital, New Haven, Connnecticut.

Dr. H. Bruno Arnold, 1442 Chapel Street, New Haven, Connecticut.

Dr. John C. Allen, Hartford Hospital, Hartford, Connecticut.

CARDIAC CLINICS

Bridgeport

City Dispensary
Every Thursday, 2:00 P. M.

Danbury

Danbury Hospital
Third Friday of each month, 9:30 A. M. to 11:30 A. M.

Crippled children clinic,* Danbury Hospital
Fourth Thursday each month, 9:00 A. M.

Derby

Crippled children clinic,* Griffin Hospital
First Thursday of each month, 9:00 A. M.

Hartford

St. Francis Hospital
Every Wednesday, 10:00 A. M.

Hartford Dispensary Cardiac Clinic
Adults—every Wednesday by appointment
Children—twice monthly by appointment

Middletown

Middletown City Department of Health
Second and fourth Tuesday of each month, 9:00 A. M. - 11:30 A. M.

Meriden

Meriden Hospital Cardiac Clinic
Third Tuesday of each month, 1:00 P. M.

New Britain

New Britain Hospital
First and third Monday of each month, 10:30 A. M.

New Haven

New Haven Dispensary: Heart Clinic and Work Evaluation Clinic
Every Wednesday, 2:00 P. M. - 4:00 P. M.

New Haven Dispensary: Pedatric Cardiac Clinic
Every Friday afternoon

Rheumatic Fever and Cardiac Diagnostic Clinic—Yale University Department of Pediatrics
Every Tuesday and Wednesday

Norwalk

Norwalk Hospital
Fourth Thursday of each month, 10:30 A. M.

Norwich

Rheumatic Fever and Cardiac Clinic,* William Backus Hospital
First Tuesday of each month, 9:00 A. M.

Putnam

Day Kimball Hospital
Third Tuesday of each month, 10:00 A. M.

Crippled Children Clinic,* Day Kimball Hospital
Fourth Tuesday of each month, 9:00 A. M.

Rockville

Rheumatic Fever and Cardiac Clinic,* Rockville City Hospital
Once every 3 months—First Wednesday, 1:00 P. M.

Stamford

Stamford Hospital
Every Thursday, 9:00 A. M.

Stamford Hospital Pediatric Cardiac Clinic
Every Thursday, 9:00 A. M. - 12:00 noon

Torrington

Crippled Children Clinic,* Charlotte Hungerford Hospital
Third Wednesday of each month, 9:00 A. M.

Charlotte Hungerford Hospital
Every second Saturday of each month, 9:00 A. M.

Waterbury

Chase Dispensary
Tuesday and Fridays, 9:00 A. M.

St. Mary's Hospital
Every Wednesday, 9:00 A. M.

Willimantic

Windham Community Memorial Hospital
Last Monday each month, 9:00 A. M.

Crippled Children Clinic,* Windham Community Memorial Hospital
Third Thursday of each month, 9:00 A. M.

*State clinics where children with rheumatic fever and heart conditions may be referred.

1951 SUPPLEMENT TO REVIEWS OF MEDICAL MOTION PICTURES NOW AVAILABLE

The Committee on Medical Motion Pictures has completed the 1951 supplement to the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures." This supplement contains 90 reviews of medical and health films reviewed in *The Journal of the AMA* from January 1, 1951, through December 31, 1951. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession.

Copies have been sent to the secretary of each of the State Medical Societies. Complimentary copies will be sent to county medical societies and other medical organizations upon request, from Committe on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

MANUSCRIPT EDITING SERVICE ESTABLISHED

To improve medical journalism, the American Medical Writers' Association has recently established the first "Manuscript Editing Service" to be conducted by a medical association in the U. S. For a small fee the Association will edit and criticize medical manuscripts (up to 5,000 words). Its aim is to help authors carry out the dictum of Sydney Smith: "The writer does the most who gives his reader the most knowledge and takes from him the least time." The Association is a non profit organization with no salaried officers. Its membership includes a large group of well known medical editors and writers. Principal purpose of the group is "to help maintain and advance high standards of medical literature." Further details of the new "Manuscript Editing Service" may be obtained from the secretary, Harold Swanberg, M.D., 209-224 W. C. U. Building, Quincy, Illinois.

BOSTON LYING-IN HOSPITAL POSTGRADUATE COURSE IN OBSTETRICS AND PEDIATRICS

The Massachusetts Department of Public Health and the New England Journal of Medicine (issue of February 21, 1952) announce that on April 17, 18 and 19 the Boston Lying-in Hospital, in conjunction with the Children's Hospital, will present a new course in obstetrics and pediatrics. This program is designed to acquaint New England physicians with recent advances in knowledge concerning prenatal care and that of newborn infants and those in the subsequent six months of life. The influence of nutrition on mother and infant, diabetes and other medical complications, threatened abortion, abruptio placentae, congenital abnormalities, feeding and immunization will be stressed. These and other subjects will be presented in a two-and-one-half-day program of lectures, conferences, clinical demonstrations, ward rounds and clinicopathological conferences.

Accommodations will permit attendance by 75 physicians. A complete program will shortly be published. Further information may be obtained from Dr. Crawford H. Hinman, 221 Longwood Avenue, Boston 15, or from the Bureau of Maternal and Child Hygiene, Connecticut State Department of Health.

Allen, Russell & Allen

Insurance Exclusively

31 LEWIS STREET

HARTFORD 4, CONNECTICUT

Fuller Brushes

FOR EVERY PURPOSE

Personal - Household - Industrial

THE FULLER BRUSH COMPANY

18 ASYLUM ST. HARTFORD, CONN.

Phone 2-3870

Tel. Stamford 4-4649

Established 1922

NESTLEDOWN CONVALESCENT HOME

MRS. MARY E. KENNETH, *Director*

59 Courtland Avenue Stamford, Conn.

OUR ETHICAL AND EFFICIENT COLLECTION SERVICE IS MEETING THE APPROVAL OF MORE AND MORE MEMBERS OF THE MEDICAL AND DENTAL PROFESSIONS.

MEDICAL-DENTAL CREDIT BUREAU

EARL A. RILEY
EXECUTIVE MANAGER

"Where the business side of your practice receives professional attention"

189 STATE STREET BRIDGEPORT 3, CONN. PHONE 6-3813

OUR NEIGHBORS

Rhode Island

The second complete year of the Rhode Island Medical Society Physicians Service has resulted in purchase of the Service by 1,414 groups since its origin two years ago, and these groups represent 77,288 actual contracts covering 183,969 subscribers. As a result of a direct enrollment campaign in 1951, 52,194 additional subscribers joined the Service. The total enrollment at the end of two years was 245,689 persons. Physicians Service has 742 participating physicians.

The operating cost the first year was 7.5 per cent, the second year, 6.4 per cent. During the past year the Service paid out $1,173,932 in benefits, contrasted with $380,283 during its first year.

The Rhode Island Medical Society is to be congratulated on this record of accomplishment.

NEWS
from County Associations

Fairfield

William Kaufman of Bridgeport read a paper entitled "Certain Psychosomatic Aspects of Food Allergy," before the 9th annual meeting of the American Psychosomatic Society in Chicago. Dr. Kaufman also read a paper, "Self-inflicted, Food-induced Allergic Illness," before the 8th annual congress of the American College of Allergists in Pittsburgh.

At the monthly meeting of the Bridgeport Medical Association held in the auditorium of Bridgeport Hospital on March 4, Dr. Jere W. Lord, Jr., associate professor of clinical surgery at New York University Postgraduate Medical School and chief of cardiovascular surgery at Bellevue Hospital, delivered a paper on the subject, "Surgical Treatment of Cirrhosis of the Liver and Portal Hypertension."

The second seminar of the Bridgeport Heart Association sponsored by the Bridgeport Medical Association, the Fairfield County Medical Association and the Academy of General Practice was held at St. Vincent's Hospital in Bridgeport on March 12.

New Haven

The Connecticut Commission on Alcoholism has opened a new part time consultant service in Meriden on problems of alcoholism. This new program will provide consultation service for courts, social agencies, physicians, families and individuals in the Meriden area. The service is available Wednesday of each week in the Salvation Army Recreation Building, 21 Pratt Street.

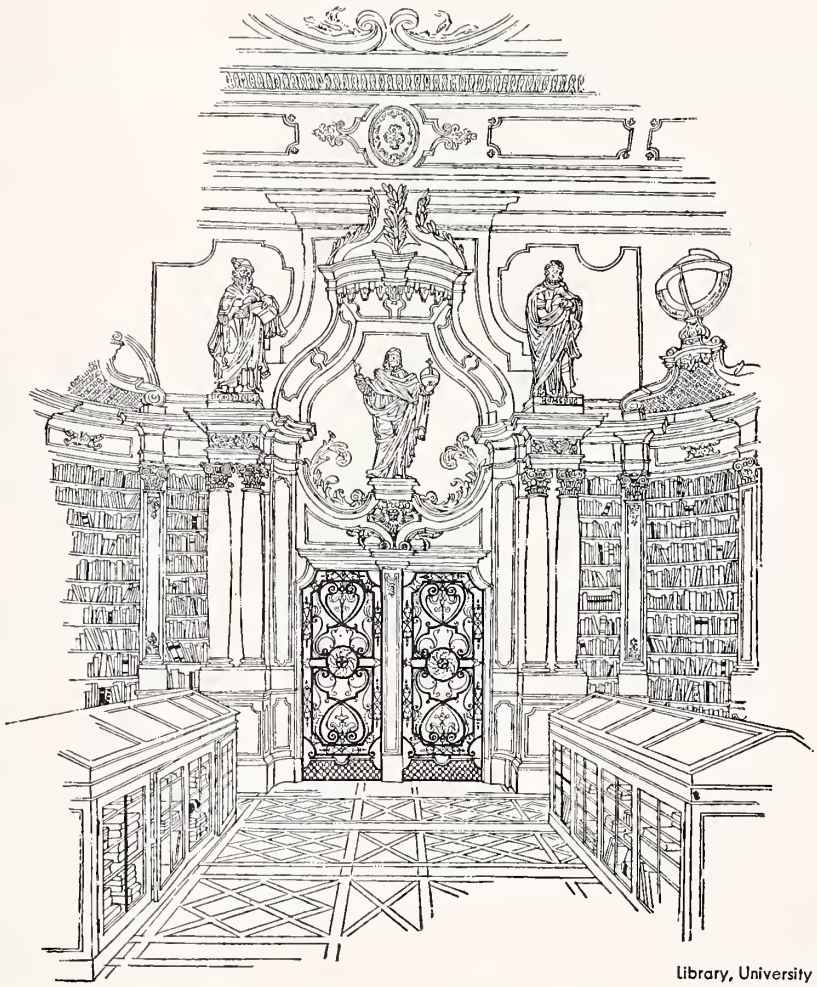
News from Yale University School of Medicine

On February 8, Dr. Abraham Schlossman was the guest speaker at the Yale University School of Medicine Postgraduate Course in Ophthalmology. His talk, "The Practical Aspects of Orthoptics," stressed orthoptics as it might be practiced by the ophthalmologist in his own office without the assistance of a trained technician. Dr. Schlossman and Miss Dorothy Parkhill, orthoptic technician at The New York Eye and Ear Infirmary, then answered questions and comments from the floor.

Clement C. Clarke commented briefly on his concepts of amblyopia as noted at the New Haven Hospital Strabismus Clinic. Frederick Wies brought up the question of why the amblyopic eye could often be brought on to a 20/30, but no better. He also cited several examples of "late" cases of strabismus that responded to occlusion. Alexander Van Heuven commented on the European schools, some of which considered orthoptics most important while others strongly opposed it.

The meeting was preceded by a clinical case of a nine year old boy with concommitant strabismus, who postoperatively demonstrated a large anomalous retinal correspondence with monocular diplopia (binocular triplopia). Miss Rachel Petrini, orthoptic technician, demonstrated with the patient how normal correspondence was established by concentrating on the dim image ("The Good Soldier").

Frederick A. Wies was speaker at the Yale Postgraduate Course in Ophthalmology on February 29. His subject was "So-called Low Tension Glaucoma."



Library, University of Belgium

from among all antibiotics, Surgeons often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin exhibits little tendency to favor the development of resistant strains of bacteria.

Aureomycin rapidly penetrates all tissues of the body, particularly those of the gastrointestinal tract, and it has been found useful prophylactically in surgery of the tract.

Aureomycin has been reported to be effective against susceptible organisms in—

Abscess
Actinomycosis
Carbuncles
Cellulitis
Empyema
Furunculosis
Gallbladder Infection
Human Bites
Infected Burns
Intestinal Perforation
Peritonitis
Soft Tissue Infection
Ulcerative Colitis
Vascular Infection
Wound Infection

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100. 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

FREE SAMPLE
DR.
ADDRESS
CITY ZONE
STATE



AR-EX MULTIBASE
New Universal Ointment Vehicle Compatible with ALL Topical Medicaments
Prescribe ointments of cosmetic elegance — made with AR-EX Multibase. Applies readily, even to hairy areas, rinses off with plain water. No screening action, making all medicaments available.

℞ AR-EX Cosmetics Inc.
Pharmaceutical Division

AR-EX COSMETICS, INC. 1036 W. VAN BUREN ST. CHICAGO 7, ILL.

He reviewed the literature on this type of glaucoma including past and present ideas on this disease and gave a detailed description of a clinical case taken from his own office. A lively discussion followed with principal comments and discussion led by Eugene M. Blake.

The meeting was preceded by an unusual case of glaucoma in a twenty-one year old white male who presented both serious diagnostic and therapeutic problems.

NEW BOOKS IN REVIEW

ANTIBIOTIC THERAPY. By Henry Welch, PH.D., and *Charles N. Lewis*, M.D. *The Arundel Press.* 1951.

Reviewed by WILSON F. SMITH

"Which antibiotic shall I use?" Is your answer to this question influenced by the detail man who most recently called on you or by a glowing report that appeared in the pile of second class mail on your desk this morning? Are you in a rut? Do you always use "streptopenimyxin" because it is the one you started using and is the one with which you are most familiar? How can you possibly keep up with the many new antimicrobial agents and the varying indications for their use? Drs. Welch and Lewis have supplied the answers for you to these and many other questions in their complete yet readable volume called "Antibotic Therapy."

Although called a "clinical desk guide," the book contains 562 pages, approximately one half of which are devoted to the historical development and detailed descriptions of the present available antibiotics. These first pages are interestingly written and include portraits and brief biographies of the discoverers of these agents. Each antibiotic is covered in considerable detail by a chapter containing its antimicrobial spectrum, pharmacology, charts showing blood levels and rates of excretion, dosage forms and finally a good bibliography. The second half of the volume contains descriptions of the susceptible diseases including diagnostic characteristics and outlines for general therapy. It is in this half that most of the practicing physician's questions are answered, for here the experience of others is summarized and the logical choice of the most suitable agent is reached. Alternate choices are discussed and an adequate bibliography concludes each disease.

This book certainly does provide a reliable clinical guide covering every phase of antibiotic chemotherapy, but it has the fault of all texts on subjects that are rapidly advancing, namely, it is about a year behind times on the day it is published. Perhaps what we really need for a "clinical desk guide" is a much smaller manual with information presented in outline form and annual revision.

YOUR DIABETES. (Revised Edition.) *By Herbert Pollack*, M.D. and *Mary V. Krause*, M.S. *New York: Paul B. Hoeber, Inc.* 1951. 212 pp. $3.

Reviewed by BARNETT GREENHOUSE

This revised edition is another good book for the diabetic's library. It is orthodox in its appraisal of a subject which has in recent years been confusing to both physician and patient because of a variance in the interpretation of diabetes control.

Slowly but surely, under the influence of the American Diabetes Association, uniformity of opinion is being formulated as evidenced by the introduction of a simplified exchange diet system and an accepted procedure for use in diagnosing diabetes.

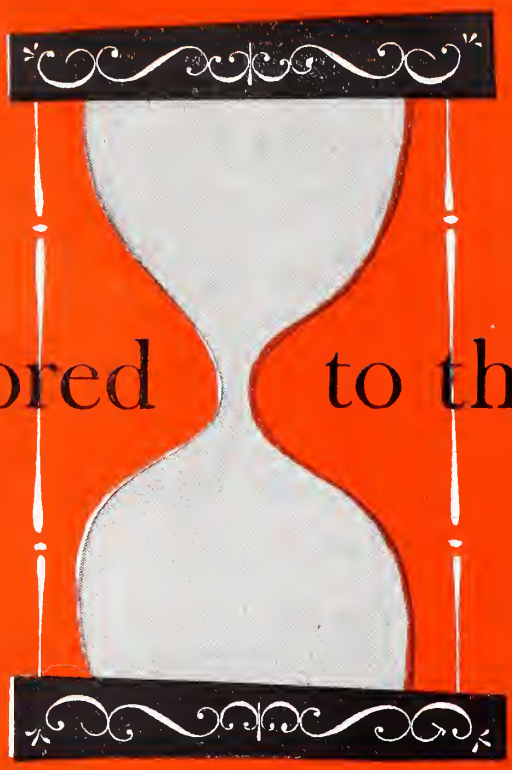
This volume subscribes to the diet exchange system and details it. Unfortunately you soon get lost in a series of other diet outlines which you have no will to persue. A most difficult approach to the diabetic diet is the effort to follow old racial food habits, or to revolve the diabetes around accustomed eating habits. The diabetic diet can otherwise be made very simple.

The diabetic must eat on time. Those who would sleep late on a morning should either reduce the insulin on the day before to avoid possible insulin reaction, or on retiring eat half of next day's breakfast.

There is a note of interest on the use of alcohol by diabetics. No opposition is voiced against the nondistilled alcohols such as wines, champagnes and beer, if the sugars they contain are calculated in the diet. Not so with distilled

AVOID "OVERTREATMENT DERMATITIS"
"Overtreatment dermatitis is today a prevalent and often disabling cutaneous disturbance."*
*Lane, C. G., Therapeutic Dermatitis, New Eng. J. Med., 246:77-81, 1952
AVEENO . . . the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.

E. FOUGERA & CO., INC.
75 VARICK ST., NEW YORK 13, N. Y.
Please send professional samples of AVEENO®.
M.D.
ADDRESS
CITY STATE



tailored to the moment



Whenever capillary bleeding becomes a hazard in surgery

Gelfoam*

BRAND OF ABSORBABLE GELATIN SPONGE

is tailored to fit the situation.

Gelfoam may be speedily cut to shape and pressed against oozing capillary surfaces, where it rapidly *absorbs* up to 45 times its own weight in blood. Left *in situ*, Gelfoam is completely *absorbed* in 20 to 45 days with virtually no cellular reaction.

Gelfoam is supplied in a variety of convenient sizes, including a sterile surgical sponge, dental pack, prostatectomy cone, and biopsy sponge.

**Trademark Reg U. S. Pat. Off.*

a product of **Upjohn Research**

for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

liquors, for alcohol removes inhibitions and leads to temptation to indulge in harmful excesses.

The use of alcohol even in impaired peripheral circulation is discounted with the statement that there is no evidence that alcohol can dilate an arteriosclerotic vessel, and its use for this purpose is an abuse.

The blood sugar is a dynamic variable and may change quickly. To be of value the blood sugar tests should be taken at different intervals throughout the day, not only fasting. Tests taken two hours after a meal will show the diabetic's real ability to use the sugar being poured into his blood stream. The physician must not ask a patient to delay or omit a meal in order to have a blood sugar test, for it causes a disturbance in his routine and may induce an insulin reaction. If, therefore, the physician is called upon to choose between not knowing the patient's blood sugar level, and the possibility of causing a hypoglycemic reaction, it is better he should not know the blood sugar concentration.

Without explanation, the author deliberately rejects the universally adopted, and now Council accepted, NPH designation by dropping the (H) and referring to it as NP, or neutral protamine insulin. This may be a short cut but not a happy one. Neutral protamine does not adequately describe this insulin or identify it since protamine zinc insulin has approximately the same pH. NPH insulin is in effect a crystalline form of protamine zinc insulin, originally known by the code name NPC indicating its crystalline characteristic, and later changed to NPH to honor Dr. Hagedorn who discovered it.

Individual patients differ in the symptoms of an insulin reaction. It is safer to consider any change in feeling as an insulin reaction than to neglect or put off doing anything about it. The urine test may be misleading. If found positive it should be rechecked on a freshly secreted second sample and if the patient is suffering a true insulin reaction, no sugar will appear. However, if an insulin reaction is suspected, it is always preferable to treat the patient as though this was actually the case, rather than waste time to make such an accurate diagnosis. He should take some sugar at once, even at the risk of provoking glycosuria.

The symptoms evoked by insulin reaction are ascribed to an adrenalin effect. As the sugar level drops rapidly there occurs a spontaneous secretion of adrenalin which liberates sugar from the liver in an attempt to raise the concentration to normal. This sudden flow of adrenalin causes the patient to experience sweats, tremors, palpitation and paleness. With the newer types of insulin, however, the drop in the blood sugar may be so slow that changes get by the body's guardian mechanisms without provoking protective actions.

There are many excellent suggestions throughout the book. Thus in speaking of diabetic coma the suggestion is made that a glass of orange juice be given, if there is no vomiting, as a protection against the possibility of mistaking an insulin reaction for diabetic coma. There is no harm in this as the subsequent use of insulin would rather make this helpful in diabetic coma.

The book is written in a lucid and interesting style and is very readable.

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

Practically new Jones, mahogany finish B.M.R. in excellent condition, for sale, $200.00. Phone Hartford 32-7188 or write Miss M. L. Jordan, 184 N. Beacon Street, Hartford.



The Empire State's Contribution to the Medical Profession

$1,000,000.00

has been salvaged from unpaid medical bills at no cost to our clients

Send this ad for details

Crane Discount Corporation
230 W. 41 St. New York 18, N. Y.
ESTABLISHED 1933

JAMES H. KANE
DRUGGIST
287 DIXWELL AVENUE, Cor. Henry Street
New Haven, Connecticut

STACKPOLE, MOORE, TRYON CO.
MEN'S AND WOMEN'S OUTFITTERS
115 Asylum Street Hartford
CLOSED ON MONDAY

Table of Contents : May 1952

The Gaylord Farm Association — David R. Lyman, M.D., Wallingford — 311

The Role of the Voluntary Tuberculosis Association — Mabel Baird, Hartford — 316

Some Observations on the Surgical Treatment of Pulmonary Tuberculosis in Connecticut — Winfield O. Kelley, Norwich — 318

Tuberculosis Control in Connecticut — Paul S. Phelps, M.D., and Reginald C. Edson, M.D., Hartford — 320

Tuberculosis—1952 — Kendall Emerson, M.D., Norwalk — 323

Some Factors Influencing Reinfection in or Reactivation of Quiescent Pulmonary Tuberculosis — George Blumer, M.D., San Marino, California — 326

The Personality of the Gaylord Farm Sanatorium — Samuel C. Harvey, M.D., New Haven — 327

EDITORIALS

Gaylord Farm 330
Pioneers 330
Grievance Committees 331
Cerebral Palsy in Connecticut 331
The Case of Dr. Lincoln 331
Accidental Deaths in Connecticut in 1951 332
Maryland Publishes State Journal 333

DEPARTMENTS

Progress in Clinical Medicine
The Hydrazine Drugs
W. Haviland Morriss, M.D., Wallingford 334
The President's Page 339
The Secretary's Office 340
The Historian's Note Book
Dr. John P. C. Foster, 1847-1910
William H. Carmalt, M.D. 344
Public Relations 346
News From Washington 349
Military Affairs 353
From Our Exchanges 356
Woman's Auxiliary 383
News From County Associations 384
News From Yale University School of Medicine 388
New Books in Review 390

MISCELLANEOUS

Obituaries
Alfred Collard Henderson, M.D. 360
John J. Keating, M.D. 360
The Doctor's Office 361
Special Notices 361
Annual Reports 362



David R. Lyman, M.D.
Medical Superintendent
Gaylord Farm Sanatorium

Air View of Gaylord Farm Sanatorium



The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. XVI MAY, 1952 No. 5

THE GAYLORD FARM ASSOCIATION

David R. Lyman, M.D., *Wallingford*

The Author. *Medical Superintendent, Gaylord Farm Sanatorium*

The first step toward an organized effort to combat tuberculosis in Connecticut was taken by the Connecticut State Medical Society at its meeting in the Hunt Memorial Building at Hartford on May 24, 1899. At this meeting its "Committee on Matters of Professional Interest in the State," Drs. Frederick T. Simpson of Hartford, Seldom B. Overlock of Pomfret and Ralph A. McDonnell of New Haven, presented a comprehensive report on "The Spread and Prevention of Tubercular Disease." This report emphasized especially the importance of a definite campaign for public education and for a state hospital for consumptives.

The prevailing hopeless attitude of the profession as well as of the public is attested by the fact that 508 of the Society's 660 members did not even reply to the exhaustive circular of the committee and that one-fifth of those who replied were opposed to the establishment of a state hospital for consumptives.

The Society voted favorably on the resolutions presented by the committee, including the following:

"Resolved: That as physicians we believe that consumptives should be in a ward by themselves and that therefore a hospital for consumptives should be built at the expense of the State.

"Resolved: That the county associations be called upon to agitate the subject and to bring it before their members, so that we may be prepared to act intelligently in the future when any action may be taken before the Legislature."

The following year the president, Dr. Charles S. Rodman, called the attention of the Fellows to this action and asked that the Legislative Committee of the Society be instructed to present this matter to the next General Assembly. Despite a very considerable doubt and some frank opposition in debate, the Fellows voted to so instruct the Legislative Committee, one of the reasons urged in favor of prompt action being "We will probably have to work for years before we get it."

Early in February of 1901 Dr. Elias Pratt of Torrington introduced in the legislature a bill prepared in consultation with the Legislative Committee of the Society. A similar bill was introduced in the Senate by the Hon. James P. Bree of New Haven.

The final bill as prepared by them and carrying among other provisions an appropriation of $100,000 for the establishment of a State Sanitarium was passed unanimously by the Committee on Humane Institutions and referred to the Appropriations Committee for action. Unfortunately, some of the members of our Society who apparently still held grave doubts as to the feasibility of treating "consumption" in Connecticut appeared at the Appropriations hearing and persuaded that Committee to pass a substitute bill appropriating $25,000 to the Hartford Hospital for an experimental sanatorium.

This was the origin of Wildwood Sanatorium opened in May 1902. Unfortunately the building was poorly planned, there was no resident physician and patients were admitted without regard to prognosis. Under these conditions it was foredoomed to failure and closed its doors in November of 1903. It was not until after Gaylord Farm's first year of successful operation that Wildwood reopened in 1905 and under Dr. William B. Bartlett and later Dr. James E. Murphy carried on successfully until its final closure in 1939.

Meantime in October 1901 the New Haven County Medical Association under the presidency of

Dr. Henry L. Swain of New Haven devoted its entire program to the subject of tuberculosis. Dr. Edwin R. Baldwin of Saranac Lake presented the main paper on "Sanitarium Treatment." Drs. Oliver T. Osborne and Frank W. Wright of New Haven and Carl E. Munger of Waterbury were also on the program.

At the close of the discussion the Association adopted the following resolution as presented by Dr. Osborne:

"Voted: That a committee of three be appointed to confer with the various Health Boards of the County and adopt some means of receiving legislative aid in the fight against tuberculosis."

Dr. Swain appointed Dr. Osborne chairman and Drs. Munger and Wright as the Committee. The Committee invited Dr. Swain, Prof. Irving Fisher and Mr. Carleton E. Hoadley, New Haven County Health Officer, to join with them.

At their first meeting on November 1, 1901 the chairman appointed three sub-committees: (1) to draft health regulations for the prevention of tuberculosis; (2) to seek suitable sites for location of a sanatorium in New Haven County; and (3) to develop plans for raising funds and for "the general management of a hospital for the treatment of consumptives."

On December 3, 1901 the Committee voted "to ask a few prominent gentlemen to unite with them in the formation of an organization to be known as the New Haven County Anti-Tuberculosis Association;" now the Gaylord Farm Association. The gentlemen so invited were Mr. Max Adler, Dr. Francis Bacon, Mr. James P. Bree, Prof. Henry Farnham, Dr. J. P. C. Foster, Rev. E. S. Lines, Mr. Joseph Porter, Rev. Anson P. Stokes and Judge William K. Townsend, all of New Haven.

This group with Drs. Osborne, Swain, Munger and Wright, Mr. Hoadley and Professor Fisher, met in the office of Dr. Osborne on May 8, 1902 and formally organized the New Haven County Anti-Tuberculosis Association. A few days later Mrs. J. Davenport Wheeler of New Haven offered the association a gift of $40,000 for the erection of an administration building and four cottages for women in memory of her parents, Mr. and Mrs. Richard Fellowes.

The Association was duly incorporated on October 17, 1902 and on November 4 adopted its by-laws and elected officers and directors. Dr. Francis Bacon was elected president; Dr. Oliver T. Osborne, chairman of the Medical Board; Dr. J. P. C. Foster, of the Executive Committee and of the Building Committee; Mr. Max Adler, of the Finance Committee; Prof. Irving Fisher, secretary and Mr. George M. Curtis of Meriden, treasurer.

On January 30, 1903 the directors voted to purchase as their site the then unoccupied Gaylord homestead on the hills between Wallingford and Cheshire, a former residence of doctors of that name since its original purchase by Dr. Moses Gaylord in 1793. Because of this it had been offered by the family through Dr. Charles W. Gaylord of Branford at a very low price. This is the origin of the name of the Gaylord Farm Sanatorium.

At this same meeting it was voted to notify the writer, then at Saranac Lake as assistant to Dr. Lawrason Brown, that he had been appointed medical superintendent of the projected institution.

In March 1903 the Association asked the State for a grant of $25,000 toward the erection and equipment of the sanatorium. This was given and it is of interest to note that this was the only capital expenditure ever asked from the State; the balance of its present plant value of over one million dollars having come from gifts and legacies.

In these times it is also interesting to note that on March 14, 1903 the Executive Committee was "empowered to expend not to exceed $12,000 as soon as such sum is available in sight, for the following purposes: remodelling the old farmhouse, stocking the farm, building quarters for the farmer and furnishing the same, building a new barn, and other incidental expenses!"

Despite delays due to changes in original building plans and a severe winter when the ground was frozen to a depth of three feet on its site, the Gaylord Farm Sanatorium opened on September 20, 1904 with accommodations for twenty patients and $92.20 remaining in the Association's treasury.

The Association did not limit its activities to the establishment of "Gaylord Farm." From its first inception its committees were consulting with the Health Officers of the county and promoting the idea of notification of cases. They were taking an active part in the efforts to improve living conditions in tenements and endeavoring through public lectures and articles in the press to educate the people as to the curability of tuberculosis and the means of preventing its spread. In 1905, chiefly

through the efforts of its secretary, Professor Fisher, it conducted the first educational health exhibit in Connecticut which was visited by more than seven thousand people in New Haven alone. In 1907 it established in New Haven the first tuberculosis dispensary in the State under Dr. Frank B. Standish, maintaining this until its activities were taken over by the New Haven Dispensary some years later.

The Directors of the Association played a large part in persuading the General Assembly in 1907 to again consider the role of the State in the control of tuberculosis. The chairman of its Executive Committee, Dr. John P. C. Foster, was chosen by Governor Woodruff as chairman of the Committee that had been authorized "to investigate tuberculosis in its relation to the welfare of the citizens of the State, and to make such suggestions as may seem practical and suitable for the control of that disease."

As a result of their exhaustive report the General Assembly of 1909 created "A Board of Directors to establish County Homes for the Care and Treatment of Persons Suffering from Tuberculosis" with instructions to establish three County Homes as soon as possible. Governor Weeks appointed Dr. John P. C. Foster of New Haven, Hon. George E. Hall of New Haven and Mr. John F. Gunshanan of Hartford members of this Board. Dr. Foster was chosen chairman at its first meeting, August 26, 1909, but contracted pneumonia following exposure to bad weather while inspecting the work under way at Shelton and died on April 1, 1910.

The Gaylord Farm Sanatorium

The activities of the Association have been largely devoted to the development and maintenance of the sanatorium at Wallingford.

OBJECTIVES

Gaylord Farm was intended primarily for people of New Haven County who were unable to afford private care in the Adirondacks or elsewhere. The failure of the other Counties to care for their own and the steady increase in the numbers seeking admittance to the sanatorium prompted the Association, before the close of its second year, to open its beds to the State at large.

The restriction as to inability to pay for private care elsewhere was maintained until the capacity of the Sanatorium was increased above 130 beds: i.e., the number upon which its current State aid was based. The directors then decided that, instead of asking more aid from the State, they would make the extra beds available for patients able to pay up to or over the cost of maintenance. They also decided, and wisely, to charge no one more than cost of maintenance and to make no distinctions as to housing, care or discipline regardless of the amount any patient might pay. By so doing they preserved the spirit of democracy that has always been one of the attractions of Gaylord Farm.

Realizing the high value of peaceful surroundings in enabling patients to relax over long periods of inactivity, and despite criticism for "extravagance" they adopted the "cottage" plan for their sanatorium. Even before the buildings were completed they began planting trees and shrubs to beautify the grounds, with the result that the patients today on their ground-floor porches live in homelike surroundings with little of that quality known as "hospital atmosphere."

Gaylord Farm has always adhered to the system of keeping its patients in groups on its sheltered porches, where the use of electric blankets has now eliminated the discomfort of "sleeping out" during the winter months. The "camaraderie" among the patients is a great help to their morale, especially to that of the new arrivals. The ever changing panorama of nature on the nearby grounds is far more conducive to relaxation in mind and body than the finest of distant views. In addition, at least in the writer's opinion, the open air porches greatly reduce the risk of infection. In the forty-eight years of its operation there have not been half a dozen cases of tuberculosis develop among its staff and employees, an incidence which stands comparison with that of almost any occupation, and routine mask and gown technique has never been employed.

MEANS OF SUPPORT

Gaylord Farm was founded for the purpose of providing the best of medical care for people of limited means. The resulting annual deficits have throughout the years been met from state grants-in-aid, yearly contributions to the Association and income from endowments. In addition to its portion of the maintenance deficits the Association has borne all capital expenditure for the development of the Sanatorium since the original State grant of $25,000 in 1903.

The State grants have always been on an entirely different basis from those to the general hospitals, those to Gaylord Farm having been given to help

meet the maintenance deficit on all part-pay patients. In 1925 this State-aid was $40,500 a year or $6 per week for the 130 cases then in the Sanatorium. The Association carried on from this point for twenty-two years without asking further State-aid or increasing its charge to patients. In 1947, faced by the dual problems of inflationary costs and deterioration of buildings and equipment, it was forced to do both.

Recognizing the essential value of Gaylord Farm in supplementing the work of our excellent State sanatoria by providing semiprivate care for those unable to relax and rest in larger ward accommodations, the Legislature raised its grant to $150,000 annually. This means that on the basis of 130 cases the State now pays $22 per week, the patient $21 and the Association $24 toward the present maintenance cost of $67 per week. Even with this large increase in State-aid the Association could not have carried on its work and continued its free-bed aid to needy cases save for the growing realization by our people and especially by our industries of the importance of Gaylord Farm to the health work of our State. This has been evidenced by the steady rise in its yearly income from these sources from $19,000 in 1943 to over $65,000 in 1951.

RATES

The Association has taken especial pride in the fact that, since the opening of the Sanatorium in 1904, the rate charged the patient has always included all essentials of regular treatment: i.e., medical service, nursing, x-rays, laboratory work, routine medications and infirmary care when needed.

When Gaylord Farm opened on September 20, 1904 its charge to patients was $7.25 a week. This was raised to $12 in 1920 and to $15 in 1926. This charge remained unchanged for twenty-one years when it was increased in 1947, to the present figure of $21. The Sanatorium has, however, always adjusted its rates to meet the needs of suitable, deserving cases, making up the added deficits from endowment and gifts for that purpose supplemented from the current funds of the Association. The annual total of this free-bed aid has averaged more than $20,000 over the last twenty years.

The Sanatorium has no endowed beds but gives reduction in rates on the basis of individual needs, often making it possible for a patient to extend his stay for several months as a "guest" to insure, so far as it can, a permanent result.

CONTRIBUTIONS

In addition to its service to the people of the State, Gaylord Farm is widely known for its contributions to the national campaign for the control of tuberculosis.

In order to prove or disprove the economic efficiency of sanatorium treatment it started from its commencement an exhaustive follow-up study of its discharged patients, listing their occupations and wages before and after treatment, also their loss of time from illness and annual earnings. This follow-up was carried through the first twenty years of operation.

Feeling that the true test of end results must be the ability of the patient to resume a normal life, Gaylord Farm urged its discharged cases to return to their former employment save where contraindicated by such factors as heavy physical strain or irritating dusts. This was a marked departure from the advice then generally given, i.e., "to look for light out-door work, preferably on a farm."

Its first published results showed conclusively that those returning to familiar jobs did much better than those in new ones, and that the worker in office, store, or factory had a far better chance of survival than the one with an out-door job. The *Journal of the American Medical Association* commented editorially on this (July 1910) new and encouraging contribution to the campaign against tuberculosis.

The first report on the earnings of Gaylord's discharged cases, first published in 1911, showed that the earnings of its ex-patients had already been double the total expenditures for building and maintaining the Sanatorium. At the end of ten years this ratio had increased to three to one, and at the close of twenty years to seven to one. At that time the total expenditures had been $1,750,000 and the earnings of its former patients $11,960,000. In addition, the ex-patients then living had earnings of almost a million dollars annually.

These figures were extensively and effectually used to convince State legislatures throughout the country of the economy of building sanatoria for their people.

DIETARY

Gaylord Farm pioneered in the use of a sane dietary at a time when "forced feeding," i.e., three heavy meals plus six raw eggs and two to three quarts

of milk daily, was the vogue. Its reports on gains in weight of its patients, showing a higher average than in institutions employing forced feeding was influential in leading to a dietary reform.

REST

Gaylord Farm insisted on the essential value of rest when sanatoria in general were emphasizing the "hardening up" of their patients before discharge. Many used their patients in place of hired employees and in one prominent institution the only paid employee was the chef. Another was given a medal at the International Congress on Tuberculosis in 1908 for its system of graduated work. It provided its patients with small, medium and regular sizes of picks, shovels and wheelbarrows and used them to build its reservoir and roads! Comparison of their after-records with those of Gaylord Farm demonstrated the marked superiority in life expectancy where "rest" was emphasized and led to the general acceptance of this cardinal principle of treatment.

FAMILY STUDY

Just prior to the depression of the thirties the Sanatorium, with the assistance of the Hazen Foundation, started a "family study" in which it sought to secure a history, physical examination, x-ray and tuberculin test on every member of the household of each new patient. This study had covered 604 individuals before being discontinued because of lack of funds.

Dr. W. H. Morriss' interesting summary of its limited activities included one finding which the writer has often used to counteract the fear of danger from casual contact in social or business affairs. He recorded the findings in the consorts of the first one hundred married patients. Here was a group where the disease had been recently discovered, where no precautions had been taken and where there had been the maximum exposure conceivable. If there be any risk in casual contacts among adults, few of these could have escaped. While the study showed a higher ratio of previous infection in these, it showed but 6.25 per cent of manifest disease in them as against 8.4 per cent for the group as a whole.

PREGNANCY

Gaylord Farm made a valuable contribution to the problem of the relation of tuberculosis and pregnancy. Its study of the records of 1818 women followed for from 2 to 27 years after discharge was the largest group in medical literature from the records of a single institution. This study divided the women into three classes: (1) those married before entering the Sanatorium; (2) those married after discharge; and (3) those who remained single. It recorded the results where active disease occurred just prior to pregnancy, during pregnancy and in the months following delivery. It brought out for the first time in medical literature the striking fact that the woman who married after leaving the sanatorium (this group had averaged between two and three babies each) not only had a better chance of life than those previously married but when compared class by class, i.e., disease early, moderate or advanced, sputum positive and sputum negative, had a far superior life expectancy than her sister patient who had remained single.

The Association has always considered that it could be of most service by using its sanatorium to care for cases in which there was a reasonable chance of permanent benefit. It has never adhered strictly to this but its small infirmary has limited the number of acutely ill patients for whom it could care at any one time. With the recent opening of nineteen infirmary beds in its new medical building and with the results now obtainable through modern therapy Gaylord Farm offers to the people of Connecticut a better service than ever before in its long history.

The Association plans, as in the past, to maintain in "Gaylord Farm" a small and friendly place where each patient is a person whose individual needs and problems receive due consideration.

THE ROLE OF THE VOLUNTARY TUBERCULOSIS ASSOCIATION

Mabel Baird, *Hartford*

The Author. *Executive Secretary, Connecticut Tuberculosis Association*

It is more than a coincidence that the 50th anniversary of the founding of one of Connecticut's most important institutions in the fight against tuberculosis should precede by only a short time a similar anniversary of another nonofficial organization, the National Tuberculosis Association. For in 1904 the one man largely responsible for the success of Gaylord Farm Sanatorium was also one of the founders of the National Association—Dr. David Russell Lyman. Few people have had more opportunity of working with Dr. Lyman than this writer, or of associating with him in both the official and voluntary tuberculosis movement in this State. His informality, keen sense of humor and constant friendliness soon dispelled the fears and insecurities of one who came to the strange city of Hartford in 1914 to work with the State Tuberculosis Commission, and for the first time to live the great distance of "forty miles from home." Consequently, to outline the background and functions of the present Connecticut Tuberculosis Association it is necessary to go back to the days when Dr. Lyman was a member of the Commission and to bring the story up to the present time.

It was during this early period when Dr. Lyman was on the Commission and also served on the Board of Directors of the National Tuberculosis Association that the request came to the Commission to handle the annual sale of Christmas Seals, to organize local committees throughout the State and to promote the campaign and develop a program of tuberculosis education and demonstration. The writer being the newest on the Commission's staff was assigned to the work of the Christmas Seal campaign and, consequently, remained associated with that phase of the Commission's program until the reorganization and establishment of the present Association. For more than 25 years the Commission acted as agent of the National Association in Connecticut, and the campaign increased from a few thousand dollars to an alltime high in 1951 of over $382,000, with 84 per cent being retained and expended in the local communities where it is raised.

Recognizing that the sale of Christmas Seals with its attendant educational program and organization of local community associations was not the official function of the State, the Commission in the fall of 1939 took steps for relinquishing this phase of its work and formulated plans for the creation of a voluntary state tuberculosis association in line with the requirements of the National Tuberculosis Association for a democratic group of medical and lay citizens. Here again, Dr. Lyman played an important part and served as the first president of the Association. Recognition, too, must be given to the late Dr. Joseph I. Linde who then as a member of the Commission initiated the first steps toward the organization of the Connecticut Tuberculosis Association in 1940. Thus, Connecticut became an integral part of the network of tuberculosis associations.

Because the control of tuberculosis is a universal problem, found in all areas everywhere, the program must be shared by all agencies working together, official and voluntary. This means that the disease must be found, isolated and treated and that efforts and methods for control must transcend the boundaries of a single state, local area, state or nation. The cost of fighting tuberculosis is very great and the problems it produces are many and complex. Consequently, efforts to control it and eventually to eradicate it require most intensive work on local, state, national and even international levels of action.

Because of the necessity to control the disease there came into being a voluntary movement to deal with the problem. This movement, through demonstrating, developing and in many instances actually conducting tuberculosis control activities, is in large part responsible for the even more important efforts that are now rightfully and largely centered in official governmental agencies maintaining sanatoria, public health, welfare, educational and rehabilitation services.

If tuberculosis transcends area boundaries, it must be attacked on a joint and integrated program, both on the part of the official and the voluntary agency. There must be a clear understanding of the functions and responsibilities of all agencies working toward the eradication of tuberculosis. There must also be a clear understanding of the three groups in the voluntary tuberculosis movement, the national, state and local associations. While each individual

voluntary tuberculosis association has certain duties and services to perform in its respective area, together the three agencies form a part of one over-all organization. Each is dependent on the others for strength and effectiveness, and each has its own responsibilities for achieving a common goal.

The National Tuberculosis Association has been primarily responsible for establishing patterns and programs for state organizations, and without its leadership the present network of state and local associations would not have evolved. The role of the National Association is one of leadership; consultation and guidance; preparation of materials for nationwide use; development of programs of medical and social research, education and rehabilitation. Many essential activities are impossible for local or state units to carry out because of their high cost and the need for specialized personnel. These the National Association can do more effectively.

Much of the strength of a local tuberculosis association lies in the effectiveness of its state organization. To assure facilities for local use and to receive the help and guidance it needs to make it strong, the local association can look upon its state association with a sense of belonging. Local workers and local board members work with the state association and also the National Association, in a common goal for the extension of public health and the control of tuberculosis. Neither the state nor the local association can operate effectively without the other and together with the National organization they can provide a comprehensive and balanced program for conducting a campaign against tuberculosis on all levels and in all areas.

The role of the Connecticut Tuberculosis Association, like that of other state associations, is varied and serves many purposes: (1) to coordinate the efforts of all associations in order to achieve tuberculosis needs which transcend city or county boundaries; (2) to provide information on proven and accepted techniques; (3) to provide training and orientation of personnel for local areas; (4) to develop new materials, exhibits and maintain general supply services; (5) to study new trends; (6) to determine unmet needs; (7) to analyze organization and program activities; (8) to provide staff assistance on special projects and consultation service on program and administration for local associations; (9) to extend organizational and program plans to all populated areas; (10) to carry out program activities in unorganized areas until local associations can be established; (11) to conduct statewide publicity; (12) to aid in special research activities; (13) to protect the integrity of the Christmas Seal and the total organization by establishing standards for local association administration and program planning. These activities add to the value and effectiveness of each component organization.

The State association maintains a staff of specially trained workers in order to provide consultation and direct service to local associations. Such services are available at all times and often for special new projects on a temporary or demonstration basis. Intensive concentration of staff in definite areas have proved of greater value than mere consultation service. The actual demonstration of the value of a trained executive secretary has been the starting point in setting up a strong local association, and the State association often must make an effort to re-establish proper emphasis and direction of program.

In a larger area of action, the National Association serves the state and local groups in a manner similar to that of the State association, doing work and carrying out activities essential to tuberculosis control which could not feasibly be executed on either state or local levels. Neither state nor local can do the job alone. All three comprise the total effort, each dependent upon the other for existence and success.

However, it is the local association, serving on the operational level, which actually brings tuberculosis activities to the people—just as it is the local health department in the official program which carries out the control measures through direct service to the public. The general duties of the local association are many and too numerous to list. The responsibility of the local association is to implement and to give actual meaning to all of the work carried on throughout the total organization, national, state and local. Tuberculosis programs must reach the people continually and effectively. They should be subject to change, kept up to date and geared to fit into the work of all other agencies concerned with the problem of tuberculosis. Boards of directors should remain interested, active, well informed and dynamic. Agencies working on local levels, whether voluntary or official, are the foundation upon which the structure of tuberculosis control is built. Yet it must be recognized that a foundation alone is only the beginning. It is the total structure which provides maximum benefit and utility. In combination, these agencies working on local, state and national levels, form the total structure in a single nationwide organization for fighting tuberculosis. Cooperative relations and mutual understanding are the essentials for the success of all.

SOME OBSERVATIONS ON THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS IN CONNECTICUT

Winfield O. Kelley, m.d., *Norwich*

The Author. *Chief Surgeon, Uncas-on-Thames, Norwich*

Such rapid changes are occurring in the tuberculosis problem that it seems appropriate to stop and look back over the years to view some of the progress which has been made.

Following the building of the first cottage of Trudeau Sanatorium in 1884, many hospitals for the treatment of tuberculosis have been constructed throughout the country. In Connecticut, the first sanatorium to function successfully was Gaylord Farm, which had its origin in 1902. Not long afterward, because of the increasing health problem, it became necessary for the State to build other sanatoria, which are now known as Cedarcrest, Laurel Heights, Undercliff, Uncas-on-Thames and The Seaside. The work which has been carried out in these sanatoria is probably representative of accepted techniques and plans of treatment throughout the country.

During the early years of these sanatoria, the treatment consisted of rest, adequate nourishment, graduated exercise, some heliotherapy and later, pneumothorax. With the increased popularization of pneumothorax during the 1930's came the inevitable complications of this therapy, such as effusion, empyema, adhesions, bronchopleural fistula and unexpandible lung. The necessity of dealing with these complications was probably one of the most important reasons for developing surgical units where they could be treated. The first major thoracic surgery department was organized at Uncas-on-Thames, and over the period of the last twenty-five years a considerable portion of the surgery for the State sanatoria has been carried out at this unit. Specific operations consisted of intrapleural pneumonolysis for adhesions, thoracotomy for drainage of mixed infection empyemas, and many phrenic operations. It will be recalled by many that thoracoplasty did not become popular until sometime in the 1930's. Events leading to the wide acceptance of this operation are of interest from the historical standpoint. The first thoracoplasty was performed by De Cerenville in 1885. This was an inadequate operation because of the limited extent of rib resection. Brauer proposed an extensive operation with removal of the second to the ninth ribs inclusive in one stage. In 1907 Friedrich performed the operation on several patients, but the mortality was exceedingly high. Gourdet and Boiffin in 1895 made an important contribution by advocating a paravertebral rib resection for better collapse of the lung. Sauerbruch in 1909 and Wilms in 1911 popularized this paravertebral operation by employing it successfully on several patients. Information thus made available by European surgeons was used by Dr. Willy Meyer of New York who performed paravertebral thoracoplasties on bronchiectatic patients. In the fall of 1918, Baldwin and Trembley of Saranac Lake referred to Dr. Meyer a young man with extensive pulmonary tuberculosis. Even though the patient was considered to be a poor risk, Dr. Meyer performed a thoracoplasty in two stages and the man recovered. This was the beginning of thoracoplasty in New York and the progress from that time onward has been quite rapid. In our own State of Connecticut, Dr. Samuel Harvey has the distinction of performing some of the first thoracoplasties in the New England area. This work was begun at the New Haven Hospital in January 1925. He was very active in developing the thoracic surgery unit at Uncas-on-Thames where he instructed his colleague, Dr. Urquhart, in thoracoplasty techniques. This work was still in its early stages in 1930.

For several years the number of patients coming to surgery gradually increased. Those with active disease who could not be given pneumothorax or had had unsuccessful pneumothorax were very likely to receive a phrenic operation. Disease which had not responded to these measures and was still not too far disseminated was treated by multiple stage thoracoplasty. Many patients with active pulmonary

disease developed tuberculosis bronchitis. It was necessary to treat this and its resulting complications, such as bronchostenosis and tuberculous bronchiectasis, by frequent bronchoscopies. Although the treatment was generally unsatisfactory, it is surprising that some of these seriously ill patients did recover.

Those were the conditions and problems which existed at the time of my arrival in Connecticut in 1946. The problem continued to be a serious one because of the lack of a satisfactory direct attack on the tuberculous foci. Pneumothorax was still being used quite frequently, and many intrapleural pneumonolyses were performed to convert unsatisfactory collapses into more effective ones. However, more caution was used in selecting candidates for pneumothorax so that the old complications of empyema and bronchopleural fistula were noticeably diminished. Whenever the adhesions were very extensive or pleural effusion tended to be excessive, the pneumothorax was abandoned as promptly as possible. Phrenic operations were performed in these and some other carefully selected cases. Large numbers of thoracoplasties continued to be performed in those patients who failed to respond to other therapy. This principle of collapse therapy was extended even to the older thoracoplasty patients in whom compression of diseased lung had not been adequate. Transverse processes and regenerated ribs were removed in order to collapse the residual cavities in the upper lobes. Results were far from perfect, but the mortality rate was kept at a low level and many lives were saved or at least prolonged.

A particular kind of disease which responded poorly to all kinds of therapy was that with the "tension cavity." The large, round cavity with a fluid level would not close following thoracoplasty alone. As a result of several years of previous experience, a fairly satisfactory although time-consuming method was devised. This is known as the Monaldi operation. First, an anterior thoracoplasty with removal of portions of the first three ribs and cartilages was carried out. Later, a catheter was inserted through the anterior chest into the large intrapulmonary cavity. Continuous suction was then applied to the cavity in an attempt to make it collapse. When the patient's condition was improved sufficiently, the thoracoplasty was completed in posterior stages. This combination of operations was quite often effective in controlling the diseased process.

Bilateral pulmonary tuberculosis has always been a serious and difficult problem. At times, because of the extent of the lesions and impaired respiratory function, no collapse measures could be used. In the slightly more favorable cases, various combinations of procedures were used, such as bilateral pneumothorax, pneumothorax on one side and phrenic paralysis on the other side, phrenic paralysis and pneumoperitoneum, pneumothorax and contralateral thoracoplasty and rarely bilateral thoracoplasty. A relatively small but significant number of patients received thoracoplasty on one side, and the apical disease with small cavity on the other side was treated with extrapleural pneumonolysis and paraffin plombage. These generally were patients classified as poor risks, and some of them succumbed to their disease. However, the good results obtained in a fair proportion of cases made the effort seem worth while.

This was the status of the surgical treatment of pulmonary tuberculosis at the time when streptomycin became available to the sanatoria of Connecticut in 1947. It can be said that this marked the beginning of a new era in the treatment of tuberculosis. To be sure, striking results were not immediately apparent, and it was necessary to proceed with caution. The correct dosage of the new antibiotic was not known, and the excessive amounts given produced dizziness, deafness and other untoward reactions in some cases. Nevertheless, the disease of the lungs improved so much that the previously hopeless patients made sufficient progress to be considered for some form of surgical intervention. Many thoracoplasties continued to be performed for another two years with quite favorable results. The question of pulmonary resection was still a very serious one because of the previously known high mortality rates reported by various thoracic surgeons throughout the country. It was not until 1948 that we began performing a few pneumonectomies and lobectomies. The number of cases gradually increased and became more varied to include segmental resections and a few wedge resections. A moderate number of bilateral partial resections also have been carried out during the last four years. Indications at first limited to thoracoplasty failure, tuberculous bronchostenosis, tuberculous bronchiectasis, tuberculoma and lower lobe tension cavity were later expanded to include chronic foci with cavitation in the upper lobes, failure of other forms of treatment, and, therefore, elective resections in preference to thora-

coplasty. The antibiotics have enabled us also to perform pleuropneumonectomies in the presence of infected pleural spaces as well as diseased lungs. It is interesting to observe that the proportion of thoracoplasties has diminished very markedly as the resections have increased. Pneumothorax is being given much less frequently now and, therefore, there are few intrapleural pneumonolyses to be performed. Phrenic operations are scarcely mentioned except in conjunction with pneumonectomy to diminish the size of the pleural space. One might be inclined to assume that this somewhat abrupt change to pulmonary resection is a radical departure from the older and more widely accepted standard operations. However, when the old and the new methods are compared, it is obvious that the old results were not always good and that resection should no longer be considered as a dangerous operation. We have been able to maintain a very low mortality rate, and the high percentage of recoveries speaks for itself.

It must be admitted that this work could not have been done so successfully without the antibiotics: streptomycin, dihydrostreptomycin and para-aminosalicylic acid. The factor of drug resistant organisms has presented a definite problem in our surgical treatment of some difficult cases. Now we have available a new series of compounds: Rimifon or nydrazid and marsilid, which may prove to be of value in bringing us nearer to a solution of the problem of tuberculosis.

TUBERCULOSIS CONTROL IN CONNECTICUT

Paul S. Phelps, m.d., and Reginald C. Edson, m.d., *Hartford*

In 1900 there were few facilities available for prevention, isolation or treatment of tuberculosis in Connecticut. Diagnosis was based largely on history and physical findings. Patients for the most part got well or died on the basis of their inherent resistence. Lack of isolation facilities and inadequate diagnostic techniques contributed to the spread of the disease. The death rate was 187.4 per 100,000 population. These were the cold facts. The suffering, distress and financial crises of the patient, family, friends and relatives defy description. Tuberculosis or consumption as it was then called, was a common disease familiar to almost every family.

In the past fifty years, education, diagnostic aids, isolation and treatment have made giant strides forward and have been powerful tools in the hands of the practicing physician. The skilful and cooperative assistance of the public health nurse, the medical social worker, the health educator, the welfare worker, the rehabilitation counsellor—official and volunteer groups—have all been vital to the physician and to his patient. These are principal factors in the reduction of the Connecticut death rate to the present rate of 14.1 (provisional 1951).

State laboratory facilities for the detection of tubercle bacilli were started in 1905. In 1951 the number of examinations for tuberculosis in the State Laboratory alone was approximately 14,000—an increase of over 500 per cent in the last ten years.

Mass radiography was unheard of in 1900. By 1940, development of photofluorography and perfection of mass radiography technique made it possible for case finding to become a major factor in the control of tuberculosis. In 1951 over 201,779 chest x-ray examinations were carried out in the State of Connecticut through mass radiography techniques.

Public clinics or consultation services for tuberculosis did not exist in 1900. Today there are seventeen such consultation services, solely devoted to the diagnosis and follow-up of the tuberculous patient, the suspect, and the contact to open tuberculosis. These services are strategically located throughout the state to serve the physician in the evaluation of his patients. The extent to which these consultation services are used by the practicing physician is reflected by the 23,814 patient visits to these diagnostic centers in 1951.

A State Case Register and thirty or more local subdivisions have been created by the Tuberculosis Commission, providing reasonably accurate and de-

tailed current information of importance to tuberculosis control. There are approximately 16,200 known cases of tuberculosis currently being carried on the State Register.

To discuss important facts in tuberculosis control and not mention B.C.G. would perhaps be an oversight in view of the publicity given to this subject in lay magazines. Up to this point scientific and statistical evidence has not been produced to the satisfaction of many clinicians in this country that B.C.G. has the immunizing effect claimed for it, even though it has been used for 25 to 30 years in certain parts of the world. The Tuberculosis Commission strongly favors experimental studies under carefully controlled conditions by those who are in a position to carry out such studies. Such experimental work is now being carried out by the USPHS and is costly, time consuming and difficult of evaluation, but is a necessary step to a true evaluation of the effectiveness or harmlessness of B.C.G.

For all practical purposes, beds were not set aside for the care of the tuberculous patient in 1900. Today the five State sanatoria and one private sanatorium present a potential capacity of 1,715 tuberculosis beds exclusively provided for the isolation and treatment of tuberculosis—giving a ratio of 5.9 beds per death. This is in addition to temporary isolation quarters, Veterans Administration facilities, and tuberculosis beds provided in our mental hospitals. Based on the average per capita cost of $65-$70 per week for State sanatoria care, more than one half million dollars was expended for the New Haven area alone in 1951. Exclusive of the aid necessary to families because of tuberculosis, the State Legislature appropriated more than $4,5000,000, in 1951 for the maintenance of the five State tuberculosis hospitals.

From isolation and bed rest, treatment has progressed to include collapse therapy methods and later chemotherapy, which in turn made possible the more recent surgical approaches. The rest home has become the modern tuberculosis hospital where treatment is a highly technical problem demanding detailed laboratory procedures and the correlation of the patients regimen by a relatively small number of highly skilled specialists in the medical and surgical fields related to tuberculosis.

It was not until 1947 that anything like a specific medication was made generally available in the treatment of tuberculosis. This does not mean that treatment was ineffective prior to the introduction of streptomycin. Bed rest, collapse therapy and regulated exercise then as now are basic factors in the treament. However, the judicious use of streptomycin, and later, streptomycin and P.A.S. in combination with other forms of treatment have made possible a type of thoracic surgery impracticable in the past. These total advances have prevented deaths in many instances, prolonged life in most cases, relieved pain and have shortened the period of sanatorium care necessary. Certainly the dramatic drop in death rate from 35.6 in 1940 to 14.1 in 1951 must be attributed largely to advances in the medical, surgical and chemotherapeutic fields made during this short ten year period.

Wedge resections, segmental resections, lobectomies and pneumonectomies have become practicable because of chemotherapy, more skilful thoracic surgery, greater knowledge of pulmonary function, and the modern methods of administering anesthesia.

Unquestionably, the resection of diseased pulmonary tissue will go through a phase of enthusiasm in the treatment of tuberculosis that characterized the introduction of thoracoplasty, pneumothorax, pneumoperitoneum, phreniclasis and all the rest. But there are complications even in the most skilful hands, and the incidence of bronchopleural fistulae, empyema and even the mortality rate depend upon the choice of cases and the surgical and medical skill employed. It is obviously impossible to remove all infected areas of the lungs by resection, and spread of the disease may therefore occur following resection.

Isonicotinic acid hydrazide, the most recent development in the therapeutics of tuberculosis, if it proves to have a comparable effect in humans as has been demonstrated in animals—will have its important place in the treatment of tuberculosis, but also its limitations. It was two or more years after streptomycin began to play an important role before resection of diseased pulmonary tissue began to have its effect in the treatment of tuberculosis. It is more than likely that isonicotinic acid hydrazide will have an effect in the treatment of tuberculosis that may be even greater than that of streptomycin, but up to this point clinical evidence is not available to substantiate assumptions based on animal experimentation. Like streptomycin its effectiveness, if one is permitted to prognosticate, will depend largely upon the choice and/or combination of therapeutic measures adopted in individual cases. Basically the success of

treatment now depends upon bed rest, good nursing care, graduated exercise, combined with a judicious selection of appropriate therapeutic measures, both surgical and medical, under close medical supervision in tuberculosis hospitals.

There are numerous other factors in tuberculosis control that play a very important part. One of the many contributions of the public health nurse was the 15,246 home visits made in behalf of tuberculosis in 1951. The voluntary agencies, such as The Connecticut Tuberculosis Association and its local affiliated organizations, have played an important role in so many different phases of the control movement. Any measure of success in health education must consider the splendid contributions of the Christmas Seal organizations. They have cooperated fully with the official agencies in tuberculosis control and have stimulated, encouraged and supported financially and otherwise almost every phase of statewide and local programs. In few states do such mutually cooperative arrangements exist between the private sanatorium, the voluntary agencies and the official state agencies concerned with tuberculosis control.

Table 1 illustrates some points worthy of consideration.

Table 1

Newly Reported Cases—Deaths and Death Rates Per 100,000 Population from Tuberculosis All Forms and Sanatorium Applications Received—Connecticut 1940-1950

	NEWLY REPORTED CASES	NO. OF DEATHS	DEATH RATES	SANATORIUM APPLICATIONS RECEIVED
1940	1221	609	35.6	1037
1941	1325	610	34.6	1314
1942	1586	623	34.2	1480
1943	1280	607	32.5	1362
1944	1371	661	34.9	1282
1945	1293	657	34.5	1134
1946	1044	579	30.2	1062
1947	1213	522	27.0	1161
1948	1581	525	27.0	1209
1949	1472	420	21.2	1248
1950	1289	332	16.5	1249

Newly reported cases in the last ten years remain almost unchanged, and applications to state sanatoria have increased slightly, although the number of deaths and death rates have dropped rapidly and significantly in this ten year period.

Case finding associated with consultation services and mass radiography has kept the newly reported cases and sanatorium applications high. Earlier cas found are more amenable to treatment and hav lowered the number of deaths from tuberculosis an the death rates.

Marked progress has been made in the last fift years, but much remains to be accomplished and co trary to the hopes of all of us, the control of tube culosis is not just around the corner. This is a tin for continued action rather than a time to slo down.

1. There is a waiting list for sanatorium admissio ranging from a low of 150 to a high of 350, in spi of the potential 1,750 sanatorium beds in Connect cut. 400 hospital beds are not now in use. This prob lem must be solved.

Housing for employees in the State sanatoria h been one of the major factors in making it impo sible to secure sufficient personnel to open close beds. This problem has been partially solved withi the last few months and will probably be completel solved within the next year and a half.

The need for alterations and/or renovations c certain state sanatoria buildings has left over 10 beds empty for several years. Recent appropriatio from the State Bond Issue will correct this in th future.

Lack of nursing personnel, aside from housing, h kept a varying number of beds closed for sever years. This continues to be an unsolved problem an will remain so until there has been a reallocation c nursing duties and responsibilities, separating thos functions which are the responsibility of the regi tered nurse from those functions which can be pro erly and effectively performed by other classific tions of workers under nursing supervision.

The waiting list will not cease to exist until thes factors have been completely solved. The fact th Gaylord Farm Sanatorium is increasing its capacit from 115 to 145 beds will also make its contributio to the solution of this problem.

2. Connecticut still has a "Means Test" for hos pitalization, which in some instances delays admi sion, and in many instances adds to the financi burden that the patient's family has to carry.

3. Only 14.7 per cent of the patients admitted t the sanatoria are in the minimal stage of the disea which constitutes a serious handicap to effecti treatment and permanent cure. 30.2 per cent of th patients in State sanatoria leave against advice befo they have received maximum benefit from san

rium experience. Of 269 such discharges in 1951— or better than 33 per cent had a positive sputum. f 1,045 admissions to State sanatoria in 1951—308 ere readmissions. The fact that 30 per cent of all ate sanatorium admissions have had previous sana- rium experience again demonstrates that tubercu- sis is a chronic relapsing disease.

4. A considerable number of patients with active berculosis refuse to accept hospitalization and main at home to infect others. Since the advent streptomycin, home treatment has become in- easingly apparent. Whatever the cause—lack of derstanding, financial worries or the false hope at adequate treatment is possible at home—home anagement of active tuberculosis is extremely diffi- lt under the best of circumstances—is rarely ade- ate and often dangerous, and every effort should made to have the patient accept hospitalization.

5. Only a small percentage of the general hospitals ke a chest x-ray on any appreciable number of hos- tal admissions, yet 1 per cent to 3 per cent of all spital admissions have unrecognized tuberculosis.

6. Pre-employment x-ray examination is becoming creasingly recognized as a valuable procedure but still practiced by a relatively small number of dustries.

7. X-ray examination of the general adult popula- tion reveals that 0.6 per cent have evidence of tuberculosis. The disease is active in approximately ⅓ of this number which means that perhaps 9,000 people in the apparently well adult population con- stitute a possible source of infection to all with whom they come into intimate contact.

8. There is a marked discrepancy between the known cases of tuberculosis and the reported cases of tuberculosis. This in part may be due to the impression of some physicians that tuberculosis is reportable only in its active stage. This of course is not so. According to State Statute tuberculosis is reportable, active or inactive.

In conclusion: Many advances have been made in the control of tuberculosis in Connecticut since 1900. However, tuberculosis still constitutes a major prob- lem from a social, medical and economic standpoint. If further advances are to be made, all sanatorium beds must be made available for isolation and treat- ment. Case finding should be stepped up to a maxi- mum, particularly as it concerns hospital admissions where chest x-ray examinations should be a routine procedure. We still need the cooperative efforts of all groups and individuals if we are to continue to make progress in the control of this disease.

TUBERCULOSIS — 1952

KENDALL EMERSON, M.D., *Norwalk*

The Author. *Formerly Managing Director, National Tuberculosis Association*

THE mid century is a fitting time to review briefly the progress in tuberculosis control during the fty years just past. It is especially appropriate ere in Connecticut for 1952 marks the fiftieth anni- ersary of the founding of one of the few outstand- ng private sanatoria in this country, Gaylord Farm t Wallingford. The personality of an administrator etermines the success or failure of such an enter- rise. Trudeau at Saranac demonstrated this truth. yman at Wallingford has carried on with rare skill nd ability throughout these many years. Our State ay well be proud of such achievement and of the man whose devotion and personality have made it possible.

During this period vast changes have taken place in our understanding of tuberculosis, the methods of its control and treatment, and the possibility of its ultimate eradication. As far back as 1937 Dr. Wade Frost demonstrated epidemiologically that this possibility could be made a reality even with the public health control methods then available, pro- vided we intensified our efforts sufficiently. The goal is still distant but new methods and discoveries give us courage to pursue it still more energetically.

The year 1952 opens on a cheerful note in this connection. Mortality from tuberculosis is reported to have reached a new low for the year just past.

Estimates indicate that it may fall to a point nearing 20 per 100,000 for the population of the country as a whole, and a provisional figure of 15.9 has been set for the State of Connecticut. It is no mean achievement to have reduced the death rate to 10 per cent of that prevailing in 1900 even though it has taken fifty years to do it.

Yet there is one fly in the ointment. It has been revealed by the admirable procedure of x-raying large groups of unselected citizens apparently in good health. Most film pictures show no suspicious pathological changes. But a small minority does in whatever part of the country mass x-ray projects are carried out. This indicates clearly that while we are thwarting the lethal effect of mycobacterium tuberculosis, we are still far from controlling its panepidemicity. A recent British writer designates tuberculosis as "a disease which has no frontiers." Quarantine cannot be used against it as is possible in foci of plague, cholera or yellow fever. Segregation in sanatoria is our best substitute. But even this has its drawbacks. First there are not enough beds, second discharge against advice is still current, releasing infectious cases again into circulation.

The State of Connecticut has maintained a foremost place in its antituberculosis campaign. This may be partly due to its rather unique allocation of responsibility for tuberculosis control to a special commission reportable directly to government. Collaboration with the public health service is implicit and effective. It is a good illustration of New England pragmatism, characteristic of Connecticut, and perhaps one of the things that make it so good a state to live in.

At all events the Commission has succeeded in convincing successive legislatures of the necessity for adequate financial support much better than in many other areas. The result is evident in the excellent sanatoria well located in the state, efficient tuberculosis clinics also wisely distributed, and a shorter waiting list of patients needing hospitalization than is generally prevalent. When one adds a word of tribute to the high quality of the administrators and personnel of these institutions it is not surprising that Connecticut has won an enviable place in its tuberculosis control record among comparable industrial States.

There is no room for complacency, however, in a campaign against so insidious a disease. Tuberculosis has no respect for state boundaries. Fortunately our immediate neighbors have themselves established effective programs. But special parts of this country are not so favorably equipped. The same is true of certain areas in large cities. Travel is a characteristic of America. Our population is not stable. Migratory labor is one example of this fact. The tuberculosis division of the Federal Public Health Service collaborates with State Departments in an effort to detect unsuspected carriers of the tubercle bacillus among these considerable shifts in our population.

But tuberculosis is worldwide as well and relatively few countries have progressed so far as or beyond the United States in their schemes for its control. With the notable increase in international travel and especially in aviation and now the resettlement of displaced persons, protective immigration policies assume added importance.

The World Health Organization, seated at Geneva, has taken cognizance of the global problems of tuberculosis and malaria control and has placed these at the head of its epidemiological programs. In addition to an extensive popular health education plan it is sponsoring a widespread scheme of BCG inoculation. This has been practised in several European countries and is now spreading to other continents especially in areas where the infection rate is exceptionally high. Without arguing the general merits of this procedure, one fact may be squarely stated. It is an educational instrument of undoubted value. In regions where public health is still in rudimentary development it introduces to the peoples' minds the gravity of the tuberculosis menace.

This cursory review of the official programs developed during the past half century has omitted mention of the voluntary agencies operating in the field of tuberculosis control as auxiliary arms of the public health service. The International Union against Tuberculosis, with headquarters in Paris, originated before the first world war. Since then two wars have intervened to interrupt its work. Today, however, it reckons 53 national organizations among its adherents, holds a biennial meeting in various large cities of the world, and discusses problems of research, education, tuberculosis control and treatment. The meetings are open forums where the various problems in the several countries are given free expression and now and then a concensus of opinion is at least approached. An outstanding value is the opportunity offered for distinguished phthisiologists to meet and know each other in a social as well as a scientific relationship.

The direct objective of research in epidemiological control of disease is an effective vaccine or antitoxin against the specific germ involved. The second objective is a specific cure for the disease itself. Intensive research in these two directions has developed during the past half century. But thus far the goal has not been reached. Dr. René Dubos has recalled the fact that the decline in death rate from tuberculosis began long before public health attained the position of an accepted science, namely in the 1830's at the time of the so-called "sanitary awakening" when cleanliness, improved diet and higher standards of living were first proposed as a means for reducing illness in squalid areas.

Since 1900 social and economic forces have been mustered into service to work with the public health departments in the preventive medicine campaign. They serve with increasing effectiveness in the fields of social service, occupational therapy, rehabilitation, education and ultimately restoration to partial or full civic activity. As therapeutic measures they are proving invaluable and are generally adopted as a function of the modern sanatorium. They serve a definite end in keeping patients relatively contented in sanatoria and as such make their contribution toward lessening discharge of active cases against advice.

Treatment cannot be discussed at length in this review. Yet two aspects should be mentioned because of their immediate public interest and their bearing on the control of the disease. Since the days of Hippocrates rest has been our major curative procedure. The complete rest of a lung in active respiratory use is at best only relative, surgery has come to the rescue during the past thirty years. It began with pneumothorax with partial immobilization and has now rapidly developed into the more radical procedures of thoracoplasty or pneumonectomy. Complete arrest of the disease has followed the majority of cases so treated and patients are discharged with negative sputum.

The other aspect is the drug treatment of the disease. Probably no less than fifty "sure cures" for tuberculosis have appeared on the market. During the past decade, however, the antibiotics have aroused new hope that from them some effective remedy may be developed. Streptomycin combined with PAS has shown valuable results until the bacillus itself has developed resistance to the drug. It is still useful in short periods to prepare patients for surgical procedures.

January, 1952, marked the announcement by two highly accredited manufacturing chemical firms in this country of a new therapeutic agent, isonicotinic acid hydrazide, relatively inexpensive and easy to produce which has a surprisingly curative effect on even advanced cases of tuberculosis. Today, March 24, the writer attended a small conference in New York at which a distinguished phthisiologist from Great Britain was present, sent over specifically to confer with representatives of the National Tuberculosis Association, and a member of one of the manufacturing companies to consider the significance of this new discovery. Time alone will prove its value.

And so we reach the mid century point with the battle lines well drawn. Medicine, surgery, nursing, social work, rehabilitation, and a health minded public, all are collaborating in the fight. The tubercle bacillus may be trembling a bit but he is still far from defeat. When an enemy weakens, good generalship indicates a strengthening of the attack. Intensification of all our resources plus the hopeful addition of research, can and must achieve the eradication of the disease during the next fifty years.

SOME FACTORS INFLUENCING REINFECTION IN OR REACTIVATION OF QUIESCENT PULMONARY TUBERCULOSIS

GEORGE BLUMER, M.D., *San Marino, California*

"I cannot so properly say that he died of one *disease, for there were* many *that had consented, and laid their heads together to bring him to his end. He was dropsical, he was consumptive, he was surfeited, was gouty, and, as some say, had a tang of the Pox in his bowels. Yet the Captain of all these men of death . . . was the Consumption, for 'twas that that brought him down to the grave."*

John Bunyan, Life and Death of Mr. Badman

TUBERCULOSIS is no longer the "Captain of the men of death" as it was in Bunyan's day, yet it still might be designated a Lieutenant, Junior Grade, for, as the statistics of the National Tuberculosis Association show, it is still the number one killer in the 15 to 34 age group. In recent years such advances have been made in controlling the disease that there is a mistaken tendency to regard it as licked. This is obviously disproven by the fact that during 1950 it killed in the United States approximately 34,000 people and that, throughout the nation, nearly half a million individuals are estimated to have active tuberculosis, though many are not under treatment. The recent x-ray survey of the general population in Los Angeles County, California, showed that of 1,736,703 totally satisfactory screening films 2.5 per cent showed evidence of suspected tuberculosis. After elimination of duplications those with suspected tuberculosis were resurveyed by confirmatory films. Of 54,648 such films that were made 16.9 per cent showed evidences interpreted as old healed disease and 56.9 per cent were referred for follow up studies. Of this latter group the follow up showed 3 per cent with far advanced tuberculosis, 22.1 per cent with moderately advanced tuberculosis, and 77 per cent with minimal involvement. All of which goes to show that many cases of pulmonary tuberculosis are either disregarded by the patient or are symptomatically latent, and even after pathological examination it is not always possible to say whether we are dealing with reinfection or reactivation. It is the purpose of this editorial to point out some of the factors that may lead to a relapse. Briefly the main ones under suspicion are: (1) dietary deficiency, (2) attacks of other infectious diseases, (3) noninfectious diseases which lower the general or local resistance, (4) trauma, and (5) pregnancy. It is hardly necessary to point out that the effect of any of these factors will depend on the character and extent of the assumedly tuberculous lesions which preceded them.

As to dietary deficiency, it is a matter of well authenticated experience that in both world wars, where large segments of the population of some countries usually offering adequate food supplies were insufficiently nourished, the incidence of and mortality from tuberculosis in such areas definitely increased. Possibly some of these patients suffered from primary infections, but no doubt in many of them reduced resistance led to reinfection or the reactivation of quiescent lesions. Then too, not so many years ago when social requirements demanded that the female form should be svelte rather than curvaceous, a definite increase in the incidence of tuberculosis among young women was reported. It is true also that in some parts of the world there are always masses of people who continually live in a state of semistarvation and that the incidence of tuberculosis among them is high.

Satisfactory statistical evidence that other infections, usually acute ones, may have a deleterious effect on the incidence of active or quiescent tuberculosis is often lacking and yet there is reason to believe that this factor may sometimes be operative. During my career as a pathologist I once autopsied a number of children in an orphan asylum, who, following an outbreak of measles, died of acute tuberculosis which had not been prevalent before the measles outbreak. Some of the same group of children developed fatal infections with noma or cancrum oris. As a clinician I have occasionally noted the development of obvious signs of active apical tuberculous infection, not present on admission and confirmed by x-ray, after acute attacks of trichinosis. Influenza has the reputation of reactivating tuberculosis but the evidence is not very conclusive. It

seems not unreasonable to suppose, in spite of the lack of accurate figures, that at times infections which reduce resistance may lead to reinfection or reactivation of tuberculous foci.

There are certain diseases which notoriously increase the incidence of tuberculosis, diabetes mellitus and stenosis of the pulmonary valve of the heart for instance. Whether diabetes acts by reducing the general resistance or whether the added sugar in the blood favors the growth of tubercle bacilli is a moot question. Stenosis of the pulmonary valve presumably acts by reducing the blood supply to the lungs and reducing local resistance.

In the older literature there are many references concerning the relation of trauma to pulmonary tuberculosis. Most of the articles refer to exacerbations of pulmonary tuberculosis after chest injury and express the view that in such patients reactivation is more likely than reinfection. One difficulty in interpreting such claims lies in the fact that there is frequently no record of the patient's condition prior to the accident, the same difficulty which confronts us in an appraisal of the relation of trauma to diabetes itself. However, it is certainly conceivable that serious trauma to the chest wall or even violent general concussion might cause physical conditions which would lead to activation of quiescent lesions containing tubercle bacilli.

Finally, pregnancy must be considered. If a pregnant woman is suffering from obvious and advanced pulmonary tuberculosis there seems to be no question that it may, at times, be necessary to terminate the gestation. If, however, the expectant mother has merely minimal or presumably quiescent tuberculosis there is grave doubt that any interference with the pregnancy should be considered. Indeed, in the last months of pregnancy the enlarged uterus, compressing the abdominal contents and forcing up the diaphragm, may actually have the effect of a phrenicotomy and put the affected lung at rest.

One may conclude then that while accurate figures are often lacking on many of the possibly potential factors in the reinfection or reactivation of pulmonary tuberculosis there is ground for a reasonable belief that some of them do influence the course of this disease.

THE PERSONALITY OF THE GAYLORD FARM SANATORIUM

Samuel C. Harvey, m.d., *New Haven*

At the Centenary of the Massachusetts General Hospital in 1921 Harvey Cushing presented an address entitled the "Personality of a Hospital." In this he portrayed the intermingling factors, personal and otherwise, that in the summation led over the years to a unity which gave this institution its particular distinction.

Today we are recognizing another institution, the Gaylord Farm Sanatorium, which in a half century has developed a personality of its own, almost if not quite unique in the field of tuberculosis. For fifty years it has given very competent professional service, but beyond this it has developed an atmosphere and loyalty only comparable with that engendered by certain educational institutions. One can, without too great a stretch of the imagination, visualize its patients as a student body undergoing an educational discipline, its staff, professional and otherwise, as the faculty, and those who have gone out from it as alumni. In fact, what is learned is a way of life particularly suitable for those having tuberculosis, but in a broader sense applicable to other adversities which similarly interrupt and disrupt one's customary activities.

It may be of interest to review briefly the historical approach to the treatment of tuberculosis, omitting the more recent advances in medical and surgical therapy. This was quite empirical and goes back as far as there is written evidence. Although much of this might be dismissed as folklore, not confined specifically to tuberculosis which was not clearly defined until the middle of the 19th century, one sees constantly recurring the factors of rest, diet and climate.

The first of these was particularly enjoined in diseases of the bones and joints and naturally by surgeons, such as Paré, Pott, David, Brodie, and most effectively by Hilton in his classic, "Rest and Pain" in 1863. Diet was likewise Hippocratic and over the centuries varied according to time and place, without any apparent consistency. Milk was commonly recommended in "consumption," or general wasting, the derivation depending upon the facilities at hand for obtaining it. A legion of other dietary remedies were likewise proposed as specifics. Among the first to lay weight on the importance of an enforced and strictly regulated diet was S. Weir Mitchell who in 1877 published an essay entitled, "Fat and Blood" and having to do with the treatment of "Neurasthenia and Hysteria." Climate and exposure to fresh air and sun light is likewise ancient; the mountains and the sea were favorite prescriptions, particularly if these entailed travel over a considerable distance. That the benefits attributed to these could be accomplished *in situ* by opening the windows or moving the patient out of his sick-room was relatively lately learned. It is noteworthy that Halsted, shortly after Trudeau started his sanatorium in the Adirondacks was discussing with him "fresh air" and the non operative treatment in surgical tuberculosis, and employing it at the Johns Hopkins Hospital. With the identification of tuberculosis as an infectious disease and the discovery of the etiologic organism, sanatoria for the care of the tuberculous were established abroad, and in this country at Saranac by Trudeau.

There was then a combination of three factors employed in these, namely rest, diet and "fresh air," with a varying estimate as to the relative importance of each. That there was another factor, less tangible and difficult to define, was not generally realized; one which arose from the complete separation of the patient from his customary environment and his abrupt transplantation into another which in almost every detail was a complete antithesis.

Again, historically, a somewhat similar situation obtained from the time of Hippocrates. "To take the cure" was an ancient custom and usually in some way rationalized, as in the "incubation" in the "Aesculapian Temples" of the Greeks, the "Thermae" of the Romans, the "Bath" of the English, the "Spa" of the Germans, and religious shrines throughout the world. Many of these are in existence today and by and large deal with chronic diseases. It was not until the latter part of the 19th century that the term sanatorium was coined from the Latin word *sanatus* for health, and became characteristic of the institutions that were being set up for the care of the tuberculous. That these sanatoria differed as to the length of treatment was because of the nature of the disease.

All of these various health centers, irrespective of the rationalization involved, were in many instances effective, largely due to a change in the environment and habits of life, as well as the leaving behind, for the time being at least, of a "sea of troubles." By this disassociation, the daily stimulation of these was blocked off and they became memories only, that as time passed tended to recede into the background, the new daily contacts and experiences becoming dominant. This separation at the least served to diminish the tension of every day life, at the most to the development of a philosophical attitude toward not only the disease but also the reaction to it. This adjustment in many instances determined whether or not the patient sooner or later mastered his affliction. The transposition was dependent in very large part upon the atmosphere of the new environment, and this upon the personnel of the institution.

While it is not essential that all of these have had tuberculosis, it is exceedingly important that those who have not, have insight and understanding rarely gained without one has himself undergone this tribulation and accomplished an adjustment to it. This applies not only to the professional staff, but also to all other personnel even though they have no direct contact with the patient. Where this is the case there develops an institutional atmosphere that is conducive to the orientation of the novitiate.

This philosophy, like the other factors previously discussed, is ancient; Plato was of the opinion that the physician who had suffered from illness was a better doctor in that he had a better insight into the mind of the patient and its effect upon his disease. This has recently been well expressed by Ian Stevenson, himself both patient and doctor, in an article which should be read in full, particularly by those concerned with chronic illness. In this he says, in respect to the physician who himself has been ill: "Certainly the sensitivity to the feelings of others is greatly enhanced; and this can become a rich asset to the physician . . . Such a physician is endowed also with the rare quality better described as understanding than sympathy. It is, after all, for understanding rather than pity that the average patient seeks a doctor; yet this important talent is far

harder to acquire than the facile half virtue of sympathy; both the praise and scorn of the public for the latter are well summarized in the phrase 'bedside manner.' . . . He will convey to him not only immediate courage, but constant equanimity."*

It may seem that the less tangible factor of the atmosphere of the sanatorium has been overlabored in contrast to the more apparent and readily defined processes of diagnosis, and medical and surgical therapy. It has not been the intent to minimize in any degree their importance for without these, particularly in the latter years when such extraordinary advances have been made, the sanatorium would be indeed a "whited sepulcher."

Rather has this been done to explain in part at least why Gaylord Farm has come to occupy after fifty years the position it does in the hearts and minds, not only of its "alumni" but also of physicians and laity alike. The institution of it by the physicians of the New Haven County and a group of enlightened citizens, provided the opportunity; the very fortunate if not fortuitous choice of a physician and superintendent, 27 years of age and only four years out of medical school, himself an alumnus of Trudeau's "Adirondack Cottage Sanatorium," determined the future of the institution.

Starting at scratch, Dr. Lyman almost if not quite literally with his own hands organized and built the Gaylord. More important, by piecemeal he developed personnel whose devotion and loyalty to him and to the institution were beyond measure. As time went on most of these were former patients, who had learned from him how to adjust themselves to their diseases. They had assimilated his "understanding" of the sick patient and to a degree unwittingly served as his agents in the therapy. In this way the present "atmosphere" was built up, arising from the personality of this beloved physician. At the same time therefore, while we celebrate the semicentenary of Gaylord, we honor him who is so largely responsible for the outstanding position it occupies among the sanatoria for the care of tuberculous patients.

*Harper's Magazine, Harper and Brothers, New York, March 1950. "Illness from the Inside"—Ian Stevenson.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
BENJAMIN V. WHITE - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Gaylord Farm

Gaylord Farm Sanitorium, now entering its second half century of distinguished public service, is the fulfillment of a noble idea, the treatment of individuals afflicted with tuberculosis and their rehabilitation to normal living in fullest meaning. Its success is to be measured by the fact that no institution within our State today has greater public esteem and good will. It is because of this that sustenance has come to the Sanatorium over the years from the people of Connecticut through roots reaching deep in their hearts. It is their Gaylord Farm. We congratulate Dr. David R. Lyman and his associates on their accomplishment. The Good Book tells us that God gave to Solomon "wisdom and understanding of heart." These too, are the fine attributes found in the spirit of Gaylord Farm, which this JOURNAL is proud to honor on its 50th birthday.

Pioneers

The history of the conquest of tuberculosis in Connecticut, much of which is recorded in Dr. Lyman's survey of the Gaylord Farm Association, represents more than a simply stated triumph of medicine over disease for it also shows what can happen when public spirited men and women work together with doctors in common enterprise. This spirit of lay and professional cooperation in the attack on disease is now accepted widely as of highest potential for best results, but it is generally acknowledged that as far as tuberculosis is concerned the pioneering efforts in Connecticut led the way toward many later developments in such broad attack. Connecticut citizens have a proud heritage here. Among the earliest of these pioneers who thus worked together we wish to mention Rev. Anson Phelps Stokes, Jr., Dr. David L. Lyman and Dr. Frank B. Standish who today are seeing a great reward of their efforts, a vision which was but partially granted to many with whom they were earlier associated. To them we extend greetings and felicitations.

A pioneering effort which must not be forgotten is the significant contribution of Gaylord Farm in incorporating as an essential part of treatment a specific effort to preserve patients as useful members of society. This was rehabilitation in true essence and meaning long before that word became in common knowledge and use. Dr. Lyman in another place pays proper tribute to the contribution of Mrs. Florence R. Burgess who in the beginning at Gaylord Farm and for many years was in effect a one-woman social service department.

Again as we survey these pioneering efforts we may take a special pride in the part which was played by the Connecticut State Medical Society. To quote Dr. Lyman in his chapter in The Heritage of Connecticut Medicine, "the impetus which started our State on this crusade which has transformed hopeless consumption into the curable, preventable and controllable disease, tuberculosis, came from the action of our own State Medical Society, following the report in 1899 of its Committee on Matters of Professional Interest in the State."

Grievance Committees

A progress report as of January, 1952, by the Council on Medical Service of the American Medical Association shows that forty-two state societies have machinery and methods for hearing complaints from the public, four are developing programs and two associations are leaving the handling of grievances to component societies. Many component societies, as in our own county groups, are prepared to adjust public grievances. These local mechanisms are particularly useful in the large urban areas. The reports show that well over ninety per cent of component societies with over 300 members have such committees.

A nationwide experience has also shown that most complaints grow out of misunderstanding or lack of information and are to be amicably settled by allowing both parties to present their cases. "The grievance committee is a protective mechanism for both the public and the medical profession and should be looked upon as such."

The majority of complaints are concerned with fees and it has been found that this is due to the fact that physicians have not made clear financial arrangements with their patients before commencing treatment.

The review of the data indicates that actually the number of complaints is small and but a small proportion represents justifiable grievances against physicians.

However, the establishment of these mechanisms is publicwise highly valuable for it represents the willingness of the medical profession to discuss problems of medical care with the public. It stands to make clear to the public that the profession is no more in sympathy with physicians who ignore professional responsibilities than it is with those people who attempt to exploit physicians who do live up to such responsibilities.

The situation in Connecticut concerning the mode of operation is essentially as follows, the Committee on Professional Relations of the Connecticut State Medical Society can supplement the county boards of censors or can serve as the committee of original jurisdiction. Complaints may be filed with the secretary of the state society or with the county society involved, and hearings may originate at either state or county level. If a complaint is filed at the county level, the board of censors of that county society may choose to handle the complaint or refer it immediately to the state Committee on Professional Relations. The Committee hears the complainant, physician and other informed persons, and attempts to settle the complaint by mediation. If this fails, the matter may be referred to the Council of the State Medical Society.

Cerebral Palsy in Connecticut

The Study of Cerebral Palsy in Connecticut under the direction of the Connecticut State Department of Health is an important document and a record of high achievement. The study represents results of cooperative efforts on the part of many persons and agencies important among whom are the parents and patients who gave generously of their time. The great interest of the doctors of our State in this subject is shown by the high percentage who responded to questionnaires. Out of 2,900 physicians queried, 2,270 gave information helpful to the study. According to estimates, the total number of cerebral palsied children under twenty-one years of age in Connecticut is in the range of 1,750-2,050, a greater percentage of which are so handicapped as to require a multitude of special services. It is estimated, however, that 30-40 per cent are mildly handicapped and require no restorative services. Thus, of 131 children intensively studied, 25 per cent were found to have a mild, 35 per cent a moderate and 40 per cent a severe degree of physical involvement. There was a striking relationship between a severe degree of physical involvement and mental deficiency. Nevertheless, 66 per cent of the children appeared educable and trainable at the time of the study.

The study reveals that our State, through various agencies and through it citizens, is facing with realism the need for the better solution of a disease obscure in its origins and protean in its manifestations. There is no one plan of treatment which can be applied to each cerebral palsied child. Each is a growing person with his own special needs and the wide recognition of this by all who are privileged to administer to those needs represents the first step toward fullest development of these young people.

The Case of Dr. Lincoln

The case of Dr. Robert E. Lincoln of Medford, Massachusetts, has had quite a day in the public press largely because of the interest of Senator Charles W. Tobey and his son, a former patient of Dr. Lincoln. Senator Tobey has gone so far as to put the Con-

gressional Record to use in publicizing Dr. Lincoln's work and his relations with his State Medical Society.

From the latter standpoint, some facts are historically of interest. On July 19, 1948, Dr. Lincoln submitted to the *New England Journal of Medicine* a paper in which he claimed to present a new and important treatment of certain infectious diseases. It was rejected on August 26 as unsuitable for publication. However, at Dr. Lincoln's insistence it was again reviewed by the board of editors and again returned to him in September. Following this final rejection, letters were received by the *Journal* from patients of Dr. Lincoln accusing it and the Massachusetts Medical Society of depriving the public of important information about a great medical discovery.

Dr. Lincoln was asked to meet with certain officers of the Society to discuss his methods. This meeting took place in July, 1949, and it was offered to him that an impartial board which he might aid in selecting, would make a scientific survey of his claims. This he failed to do.

On June 6, 1951, because of charges brought against him, the Committee on Ethics and Discipline of the Massachusetts Medical Society asked Dr. Lincoln to appear before it and explain his unusual system of practice in which all diseases were treated by the inhalation of one or more solutions of bacteriophage. As a result of this interview, a special committee was appointed by the president to study these methods of Dr. Lincoln. A diversified committee was selected because Dr. Lincoln's claims of successful treatment concerned not only infectious diseases but cancer, multiple sclerosis and other conditions. The committee comprised a consultant in diseases of the chest (chairman); a consulting neurologist; chief of staff, Pondville State Cancer Hospital; chief of research division of infectious diseases at the Boston Children's Medical Center; and the assistant professor of legal medicine and acting head of the department, Harvard Medical School.

The final report of the committee after seven months of investigation contained evidence of neglected examination of patients, uncertainty of diagnosis, lack of adequate records, and ineffectiveness of treatment dependent upon a secret remedy. Charges were subsequently brought before the Society's Committee in Ethics and Discipline, Dr. Lincoln found guilty as charged and his resignation from the Society requested.

An editorial in the *New England Journal of Medicine* from which the foregoing has been largely drawn concludes with this statement, "The Massachusetts Medical Society has tried always to discharge conscientiously its function of maintaining high professional standards by declining to keep within its fellowship the proponents of any irregular, ineffective or dangerous system of practice. This it must do regardless of political pressure, public prejudice or the general lack of understanding of medicine's peculiar problems that continues to exist despite the profession's increasingly effective efforts to make its principles clear. In the present case the Society and the public are indebted to the committee that has done its work with such care."

Accidental Deaths in Connecticut in 1951

Death came to 847 persons in Connecticut during the last year either through their own doing or through the carelessness of others, a violent death rate of about 41.3 fatalities per 100,000 population. This represents a 60 case reduction over 1950. Actually the death rate for 1951 is the second lowest in the history of the State, the lowest being the 39.7 credited to 1949. Considering our increased population, high industrial activity, and peak volume of highway traffic, 1951 was therefore "satisfactory" at least statistically. Violent deaths for 1951 were 4.3 per cent of the total necrology for the year which was 19,624. Motor vehicle deaths, which were 245 for 1951 (a 47 case increase over 1949), are over-all figures, traffic fatalities being but a part of the total. Thus collision, pedestrian, motor vehicle, train, fixed object, and cyclist, accounted for 214 of motor vehicle deaths.

Seventy-five per cent of all accidental deaths were located in 44 towns of more than 10,000 population, and 58.5 per cent are charged to 21 towns, aggregating 496 cases. Thirty-five per cent or 295 deaths are reported from Connecticut's six largest cities. Of these, New Britain recorded the greatest case reduction, 1951 over 1950, and had the lowest rate of the six largest cities.

Other interesting facts brought out by the Connecticut Safety Commission in the March, 1952, bulletin are, 64 per cent of victims were males, 38 per cent were over 65 years of age, and 45 per cent were killed in home accidents.

The bulletin points out that Connecticut's rate of 41.3 may be the lowest in the nation reporting to the National Safety Council but no positive state-

ment can be made at this time. The National rate is predicted to be about 60 deaths per 100,000 population, which average, if applied to Connecticut in 1951, would mean more than 400 over our actual fatality experience.

The Commission points out that if Connecticut is to achieve a total of less than 800 cases each year it will require a substantial intensification of Community Safety Programs. The problem is not one of State level responsibility. Nevertheless much can be done in planning and encouragement from the State level.

Maryland Publishes State Journal

In January of this year appeared the first issue of the *Maryland State Medical Journal*, official publication of the Medical and Chirurgical Faculty of the State of Maryland. This organization bears a name of ancient and honorable vintage and corresponds to the medical societies founded and operating in the other 47 states and the District of Columbia.

The new publication appears in a blue and gray cover bearing the official seal of the faculty and so arranged to afford advertising space in the lower half. The contents conform to the pattern of most of the state medical journals—scientific papers, reports, county society news, and various sections devoted to civil defense, hospital news, insurance, health departments, and Woman's Auxiliary.

The type is easily legible, the paper of a good quality, and except for the front cover the advertising is well arranged.

The CONNECTICUT STATE MEDICAL JOURNAL offers its best wishes to the new baby for a successful career and congratulates the Maryland physicians on embarking upon a project for which there has long been a need.

Some Hospital Figures

Between 1946 and late 1950, more than 660 new hospitals and 20,000 additional beds were added. Investment in hospital facilities increased $1 billion.

By late 1950 approximately $8 billion had been invested in hospitals, or about $1,100,000 per hospital and $5,300 per bed.

Two million or 21 per cent more people were hospitalized in late 1950 than in 1946. There were 18 million admissions including multiple admissions in 1950 in a population of 150 million. Yet the average length of stay has been reduced by 15 per cent in the last five years, from 9.1 days in 1946 to 8.1 days in 1950.

Expenses per patient day in hospitals have risen from $9.39 in 1946 to $15.62 in 1950, a 66 per cent increase.

Patient income to hospitals per patient day has risen from $7.75 in 1946 to $13.11 in 1950, a 69 per cent increase. This makes an increase in the per patient day deficit from $1.64 in 1946 to $2.51 in 1950.

Short term hospitals found themselves a little worse off financially in 1950 than in the previous year for, while their total income increased $253 million or $1.09 per patient day, their expenses increased $278 million or $1.29 per patient day.

AMA to Stage World's Largest Medical Exhibit

Chicago—This city's half-mile long Navy Pier will be used June 9-13 to house the largest medical scientific and technical exhibits ever staged.

Three hundred scientific and 375 technical exhibits will have a frontage of more than three miles. They will occupy nearly a quarter of a million square feet of floor space, according to Thomas R. Gardiner of Chicago, business manager of the American Medical Association.

The exhibits will be held in connection with the 101st annual session of the AMA. Approximately two-thirds of the space will be devoted to the technical exposition, a presentation of informative displays by manufacturers and distributors of practically the entire scope of the physicians' needs.

The scientific exhibits, sponsored in most part by doctors, will show the latest developments and techniques in virtually every specialty of medicine. Emphasis, however, will be placed on subjects of interest to the family physician, according to Thomas G. Hull, PH.D., of Chicago, director of the AMA Bureau of Exhibits.

A registration of between 12,000 and 15,000 physicians from all parts of the country is expected at the convention. In addition, about 15,000 other medical personnel, exhibitors and guests are expected to attend. This large attendance makes it necessary to limit admission to the exhibits to AMA members and their guests.

PROGRESS IN CLINICAL MEDICINE

THE HYDRAZINE DRUGS

W. Haviland Morriss, M.D., *Wallingford*

Announcement of a new cure for tuberculosis or cancer is always an item of the greatest interest to the public and when such an announcement comes from an official agency it is sure to make the first page of our newspapers in spite of tax collector scandals and failures to arrange a Korean armistice. The premature publicity given to the new "mystery drug" said to offer "firm hopes that it will wipe out the number one contagious disease killer in a few years" is understandable if unfortunate; unfortunate in that such publicity excites hopes among the many sufferers with tuberculosis and their concerned families that may well be unfounded, also, that it may interfere with present well proven methods of treatment and reduce the patient's ultimate chance of recovery.

Cures for tuberculosis have been widely heralded before. In 1890 Robert Koch stated before the Tenth Medical Congress in Berlin that in testing many chemical substances on pure cultures of his recently discovered tubercle bacills, he had found not a few substances that could inhibit the growth of the bacillus. In 1891, turning from chemical substances to biologics he brought out tuberculin which for several years was looked on as the probable cure for tuberculosis only to be almost entirely abandoned a few years later because of the many harmful results that followed its therapeutic use.

The next wonder drug hailed with early enthusiasm was the inorganic gold compound known as Sanocrysin which was brought out in 1924 by Mollgaard, and used extensively for a few years in Europe. It, too, proved a disappointment for its healing properties were limited, its toxic effects highly dangerous.

In 1935 came the sulphones, diazone, promin and promizole. These substances again hailed with enthusiasm as a cure, were effective in vitro and in animal experimentation but were highly toxic to humans and of questionable value in treating human tuberculosis. With the advent of penicillin the medical world became antibiotic minded and in 1944 Waksman and associates discovered a new substance derived from the soil actinomyces known as streptomycin which on clinical trial gave early promise of great therapeutic efficiency. Perhaps no new and promising drug has been studied so scientifically, for cooperative programs of clinical study were set up in 1946 under the Veterans Administration, the Army and Navy, and separate investigations were initiated by the American Trudeau Society and the U. S. Public Health Service. These efficiently conducted studies, with the abundance of clinical material that they commanded, have saved years in determining what streptomycin can do, its limitations, and how it is best administered. While not the "wonder drug" that was hoped for streptomycin in combination with PAS has won for itself a most important place in the treatment of tuberculosis and its advent has brought about the greatest improvement in the prognosis of the disease in our professional lifetime. It has been felt, however, that other and better drugs might be hopefully anticipated.

Discounting the first "wonder drug" stories in the public press and the pictures of deserted beds and patients dancing in sanatoria halls, it would seem that a new drug or series of drugs has been discovered that gives enough promise to be worthy of a scientific evaluation similar to that given streptomycin.

The discovery of the new drug is interesting and at this writing seems to somewhat strain the possibilities of coincidence. Two important drug houses in this country, each apparently following the lead offered by a German antituberculosis drug tibione, which was fairly effective but too toxic, have screened out hundreds of substances allied to tibione chemically in the hope of finding a safer and better substance. Each company at about the same time came up with the same substance, isonicotinic hydrazide, as being worthy of clinical trial. To make coincidence even stranger, quoting from *Time Magazine,* it is stated that in Spain Juan Socias and Dr.

Romero also discovered this drug, calling it FSR-3 and that they have been giving it clinical trial for about a year. To complete the story, the drug is not a new chemical synthesis. It was prepared and described by two Austrian chemists in 1912, M. Meyer and J. Nally, who had no inkling that their discovery had any therapeutic properties.

Isonicotinic acid hydrazide, called Rimifon by Hoffman-LaRoche and Nydrazid by Squibb with an isopropyl derivative of Rimifon called Marsilid, were made available for clinical trial to Sea View Hospital on Staten Island, to Dr. Steenken at Saranac Lake for laboratory study, to Dr. Mead at Saranac and to Dr. Walsh McDermott and Dr. Muschenheim at Cornell Medical Center and also to Dr. Roger A. Lewis and Mr. Irving Zieper at Yale who used it in studies on monkeys with tuberculosis.

The first reports on the hydrazine drugs in a medical journal is made in a special number of the *Quarterly Bulletin* of Sea View Hospital. This special number contains five articles. The first one, from the Hoffman-LaRoche Chemotherapeutic Laboratories by E. Grunberg and R. J. Schnitzer[1] describes the discovery of the drug and experiments to test the activity of the hydrazine derivative of isonicotinic acid on mice infected with tuberculosis.

The second article by I. Zieper and R. A. Lewis[2] from Yale, reports in detail on the treatment of a Macacus monkey spontaneously infected with tuberculosis. A report by I. J. Selikoff, E. H. Robitzek and G. G. Ornstein[3] of Sea View follows on the toxicity of the new drugs. Then appears an article by Robitzek, Selikoff and Ornstein[4] who make a preliminary report on the treatment of patients at Sea View Hospital with the hydrazine drugs. The last article is by Bosworth, Wright and Fielding,[5] from the orthopedic service at Sea View on the use of Marsilid on tuberculous orthopedic lesions.

These are the first medical publications on the hydrazine derivatives and are introduced by the editor, Dr. Wainerdi, with an editorial entitled "A new epoch in the chemotherapy of tuberculosis?" the question mark being the editor's not the reviewer's. Dr. Wainerdi summarizes the content of the papers as follows: "The medical staff at Sea View Hospital . . . herein reports new effective and safe drugs with an extraordinary anti M. tuberculosis effect."

The first paper, coming from Hoffman-LaRoche, describes how the drug Rimifon was synthesized by Dr. H. H. Fox. It describes the chemical structure of Rimifon and Marsilid. Report is made in detail of in vitro experiments to determine bacteriostatic indices of both drugs and the acute toxicity by lethal dosage technique, using white mice. These tests are deemed satisfactory as showing only slight toxicity at effective dosage ranges. The bulk of the paper is then devoted to mice treatment experiments. In this series of experiments mice infected either intravenously or intranasally with H37 Rv strain of M. tuberculosis were treated for 21 days with daily dosage of Rimifon or Marsilid, the dosage varying from 25 mg. per kilo to 1.5 mg. per kilo. An adequate number of animals is reported in each of the various groups. All mice were autopsied on the 22nd day. It is reported that practically all animals were protected by a dosage of 10 mg. per kilo of Rimifon and 25 mg. per kilo of Marsilid. Cultures taken from the lungs of the protected animals showed that no viable organisms were apparently present within the effective dosage limits. All cultures made from controls and inadequately treated mice showed a heavy growth of M. tuberculosis. The authors note that the drugs under study seemed specific for tuberculosis, having no activity against other bacteria tested, protozoan infections or the virus of influenza.

In the interesting paper from Yale on the treatment of a monkey spontaneously infected with tuberculosis it is noted that monkeys are extremely susceptible to infection with tuberculosis and that they have little or no resistance against such infection. Most animals die within thirty days after infection is discovered by tuberculin testing and animals inoculated with either bovine or human bacillus die within four to six weeks. The animal studied was treated for 19 days with 10 mg. daily of Rimifon per os and then for 55 days with 100 mg. daily of a glucosyl derivative of Rimifon. During treatment the animal gained strength, appetite and 1,000 Gm. On the day after completing the treatment, the animal was sacrificed and autopsied. Evidence at post mortem substantiated the diagnosis of tuberculosis but the lesions found were minimal. Some inflammatory foci were seen in the peribronchial tissue of the lungs and one large tracheobronchial lymph node was destroyed by a necrotising process walled off by connective tissue. A small number of M.T.B. were found on smear from the pus of the lymph node but in no other tissues were organisms present and no growth on culture was obtained in three months from the pus of the

lymph node. The apparent clinical arrest of tuberculosis in this animal is considered by the authors as extraordinary and is certainly impressive to the reviewer.

In the next paper on toxicity, symptoms attributable to the drugs seemed fairly mild. The authors comment that the side reactions have been of an acute variety and largely related to the autonomic nervous system and to a much less degree to the central nervous system. No severe parenchymatous toxicity was encountered. The following symptoms are listed approximately according to the frequency of their occurrence: vertigo, constipation, twitching of the lower extremities, insomnia, drowsiness, headache, weakness of the legs, difficulty in voiding, hyperreflexia. Little is said about the severity or duration of these symptoms. A transitory slight depression of hemoglobin and red blood count is noted on a few patients with full recovery by the fourth or fifth week. A slight eosinophilia was noted on several patients reaching a maximum of 20 per cent in one patient. Urinary changes were slight, and these only occasional traces of albumin and casts. In general, the authors seemed to feel that toxicity will not restrict the use of the drug at effective dosage.

The fourth paper is a preliminary report on the results of treatment of the 135 patients undergoing treatment with hydrazine drugs at the time the paper was prepared. The statistical report is confined to 92 patients with pulmonary tuberculosis who have received treatment from four to fifteen months. All of these patients were far advanced and very ill and were selected on the basis that no other known therapy had anything to offer; in fact, they were all judged to be "hopeless." The authors stress that this is a preliminary report and emphasize that the chemotherapeutic effect of a drug observed for only a limited time can best be noted in relation to the effects on the systemic aspects of tuberculosis infection. They state that "the mortally ill patients we have studied have obtained therapeutic benefit beyond anything we have ever seen with any of the chemotherapeutic or antibiotic agents previously utilized by us." Symptomatic improvement is said to be rapid and impressive. In every instance patients became afebrile within two weeks. Toxicity symptoms were promptly alleviated. The gain of weight was truly surprising, the over-all gain being 2 lbs. per patient per week. Cough and expectoration were markedly improved or eliminated.

The changes in sputa content were somewhat less spectacular. At onset of treatment all patients were strongly positive. After four to fifteen weeks of treatment 25 per cent became sputum negative and another 28 per cent showed only occasional positive findings. Culture and animal inoculation studies on the sputa and gastric lavage specimens are not as yet reported.

X-ray changes are so far not impressive. About 50 per cent of the cases have shown no change, the others, some decrease in the size of cavities and some thinning out of areas of infiltration. The x-ray reproductions which are shown in the article of four cases before and after a period of treatment are not remarkable. Better improvement has frequently been noted by the reviewer on patients treated with streptomycin for similar time intervals. Allowance, however, must be made for the fact that the time of treatment is very short and the lesions shown are extensive and of a sort where improvement would be expected to occur slowly if at all.

Six cases are reported in some detail. All are far advanced and very ill. The weight curves are shown for all six and these show a striking gain of weight usually starting from one to three weeks after the institution of treatment. In three of these a long continued and steady loss of weight is shown on the curve before treatment was started. Temperature curves are charted for the first three cases showing a return to normal in from two to fourteen days. Symptomatic improvement is strongly emphasized in each report. The paper concludes by stating briefly that several types of extra-pulmonary tuberculosis were also treated. Ten cases of laryngeal tuberculosis, all previously unsuccessfully treated by streptomycin, showed improvement. One case of tuberculous otitis media showed under treatment rapid and marked improvement and several cases of tuberculous gastroenteritis also improved satisfactorily. Another patient with tuberculosis of the tongue showed spectacular clearing. Studies on genitourinary tuberculosis are of too short duration to be reported.

The last paper in this issue is by Bosworth et al[5] who report favorably on the healing of bone sinuses with the use of Marsilid.

Since the publication of the special issue of the *Quarterly Bulletin* of the Sea View Hospital which has been reviewed in some detail, the April number of the *American Review of Tuberculosis* containing six papers on the hydrazine drug and the April issue of *Diseases of the Chest* containing four papers on

the same subject, have reached the reviewer's desk. In the latter *Journal* Grunberg et al[6] add a supplementary note to their paper in the *Sea View Bulletin* to the effect that a high percentage of mice treated with effective dosage of the hydrazine drugs did not develop tuberculosis even after the drug had been discontinued for twenty-one days. They state that this is in contrast with findings of similar experiments using streptomycin and other antituberculosis agents and suggest that the finding indicates that the M. tuberculosis have been sufficiently damaged to prevent relapse after hydrazine treatment is stopped.

W. Steenken and E. Wolinsky in the *American Review*[7] made several points of special interest. They note definite and considerable bacteriacidal properties in the hydrazines studied in vitro. They also observe that treated guinea pigs frequently show a conversion from strongly positive tuberculin reactions to negative after one month of treatment. One is impressed when they report a small series of rabbits inoculated intravenously with a virulent strain of bovine tuberculosis who have survived in apparent good health 71 days while the five controls inoculated at the same time all died within thirty days of miliary tuberculosis.

These early reports of a new antituberculosis drug or series of drugs, while all admittedly preliminary, seem to have promise of a worth while new weapon in the treatment of tuberculosis. Its ease of administration by mouth, its apparent ability to kill M. tuberculosis, the relatively low cost of manufacture, all suggest that it may present points of superiority to streptomycin.

Many things remain to be determined before the hydrazines can find their rightful place. Their toxicity is not well determined. The optimal dosage and optimal mode of administration will require considerable time to work out. Optimal duration of treatment is entirely unknown. The important question of whether or not resistance to the drug will be developed is at this time also unknown. Follow-up studies for relapse must await the future.

It is greatly to be hoped that all these studies will be made under carefully controlled conditions as was done in the case of streptomycin.

The premature excessively enthusiastic early publicity and the fact that many of the larger drug houses are now putting out the non patentable original drug, each it may be noted under a different trade name, will make such control more difficult.

REFERENCES

1. Grunberg, E., and Schnitzer, R. J.: Studies on the activity of hydrazine derivatives of isonicotinic acid in the experimental tuberculosis of mice, Quart. Bull., Sea View Hosp. 1952, 13:3.

2. Zieper, I., and Lewis, R. A.: Tuberculosis in a macacus rhesus treated with isonicotinylhydrazine. Quart. Bull., Sea View Hosp. 1952, 13:12.

3. Selikoff, I. J., Robitzek, E. H., and Ornstein, G. G.: Toxicity of hydrazine derivatives of isonicotinic acid in the chemotherapy of human tuberculosis, Quart. Bull., Sea View Hosp., 1952, 13:17.

4. Robitzek, E. H., Selikoff, I. J., and Ornstein, G. G.: Chemotherapy of human tuberculosis with hydrazine derivatives of isonicotinic acid. Quart. Bull., Sea View Hosp., 1952, 13:27.

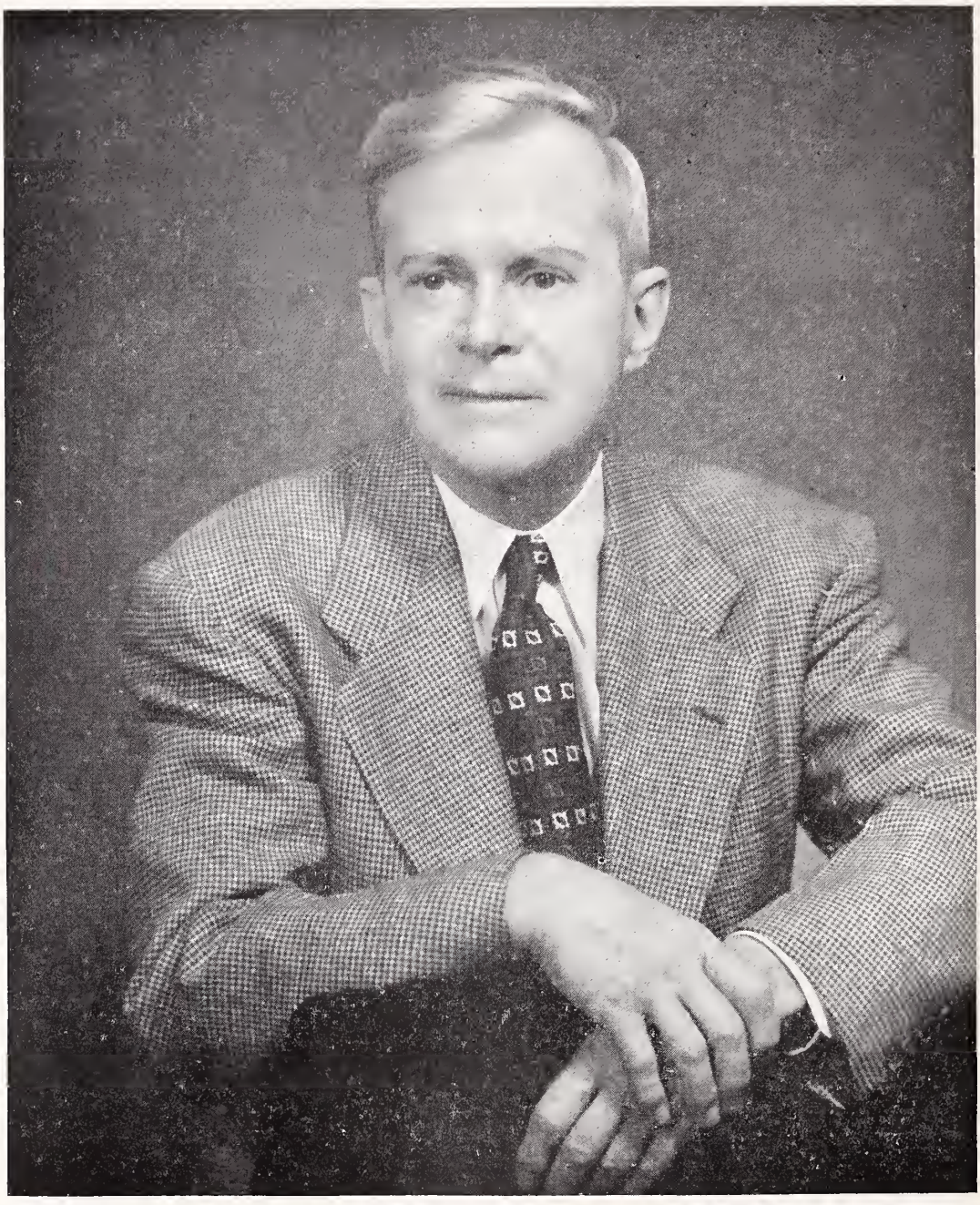
5. Bosworth, D. M., Wright, H. A., and Fielding, J. W.: Marsilid in the treatment of tuberculous orthopedic lesions. Quart. Bull., Sea View Hosp., 1952, 13:52.

6. Grunberg, E., Leiwant, B., D'Ascensio, I.-L. and Schnitzer, R. J.: On the lasting protective effect of hydrazine derivatives of isonicotinic acid in the experimental tuberculosis infection of mice. Dis. of Chest, 1952, 21:369.

7. Steenken, W., Jr., and Wolinsky, E.: Antituberculous properties of hydrazines of isonicotinic acid (Rimifon, Marsilid.). Am. Rev. Tuberc., 1952, 65:365.

Dr. Darrow Receives Borden Award

Daniel C. Darrow, professor of pediatrics at Yale University, is a recipient of one of the 1951 Borden Awards. Established in 1936 these awards are designed to recognize and encourage outstanding research achievements in the United States and Canada. They are administered by professional and scientific associations, and are based upon research reported in public documents or scientific journals. Currently nine annual awards of a gold medal and a thousand dollars each are available. Dr. Darrow was cited for the Award by the American Academy of Pediatrics for his contributions in the field of disturbances in water and electrolytes. From his researches have stemmed a number of concepts essential to the understanding of water and electrolyte metabolism, and a new era of treatment applicable in many fields of medicine. Dr. Darrow's introduction of potassium in the therapy of infant diarrhea has led to similar potassium therapy in certain other conditions in infants and children, and also has been used to significant advantage in postoperative care of surgical patients, diabetic coma, and other conditions where a deficiency of potassium was indicated.



Edward J. Whalen, M.D.,
M.D., Yale University, 1908
Intern, St. Francis Hospital, Hartford, 1908-1909
Resident Brooklyn Eye and Ear Hospital, 1915-1916
Lieutenant, Medical Corps U. S. Army, 1918-1919
Councilor, Connecticut State Medical Society, 1939-1941 and 1950-1951
Librarian, Hartford Medical Society, 1944-
Fellow American Medical Association and American College of Surgeons
President, Hartford Medical Society, 1943
President, New England Oto-Laryngology Society, 1944
Consultant in Otolaryngology to several hospitals in Connecticut

THE PRESIDENT'S PAGE

"Watch for the week in May when laylocks blow, for then the doctors meet and I must go." So sang Oliver Wendell Holmes to the doctors of the Massachusetts Medical Society in attendance at their Annual Meeting in 1870.

This month, with the laylocks, come 175 new interns and residents to the hospitals of Connecticut. The intern will be 26 years old. In his twenty-six years of life he and his family have suffered many shocks of a social, economic and emotional nature. His personality and psychic pattern differ from that of his grandfather and his father and this must be given its true value if he is to enjoy our sympathetic understanding. He has been conditioned for a socialistic state.

Youth demands the heroic and we must, during the twelve months of our association with these young men, fill this role. Interns are the children of Medicine and are curious, impressionable, imitative and enthusiastic. These distinctive traits of youth can be developed and made productive during the months we share with these young doctors. Their curiosity can be so directed as to become scientific inquiry. What an opportunity is offered to us to take advantage of this close contact and by our example, our teaching and our attitudes, make certain that these young men learn the true meaning of this glorious heritage of Medicine that has been handed down to us and that we in turn pass on to them. This need not mean that they are to be taught to be uniformists or conformists but rather that freedom of individual thought is what we hope to preserve, protect and encourage.

"Education is the hope of our youth, youth is the hope of our democracy and our democracy is the hope of the world."

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

Report of Executive Secretary 1951 - 1952

Mr. President and Members of the House of Delegates:

It is a pleasant privilege to present this report to you. The past year has been a good one for the Society. It is true there have been no exciting high spots such as planning and moving into a new building or the launching of Connecticut Medical Service, which has become a three million dollar a year business, or the peculiar exactions of trying to deal fairly with the political maneuvers of Governor Bowles, but it has been a time of quiet achievement and stable progress to which many have contributed.

First, I should pay tribute to the cooperation and understanding that I have at all times received from the officers of the Society and the members of its Council and particularly I wish to mention the unfailing help of the Chairman of the Council, Dr. Howard. It is unusual to find a person who will give so unselfishly of his time in the interest of medicine in Connecticut, not only to this Society, but to the Connecticut Cancer Society and other organizations working for the good of our profession and the public. The Society is fortunate to have Dr. Howard as one of its members.

Credit belongs to our President, Dr. Rafferty, who was hastened into office by the sad and untimely death of Dr. Burlingame, before he had an opportunity to become familiar with the Society's multitude of activities. His interest was quickly awakened and he has served you well in his quiet, modest way and it has been a pleasure to work with him.

A big organization, such as this, must carry on many of its projects by committees and I wish to acknowledge all that has been done by the dozens of members who have served on them, each person has, in some way, given something to the Society and the extent of its usefulness.

The report of the membership is before you and I shall emphasize only its final figures. The increase in membership in this Society has been phenomenal, there has been a net gain of one thousand members since 1940. The end of 1951 showed a gain of 108 and membership was at an all time high of 2,729, as you will note from the report. It is to be remarked that of that large number only nine were dropped for nonpayment of dues at the close of the year. The proportion of physicians in the state belonging to this Society is perhaps not exceeded in any other state. There are many causes for this large membership, but the chief reason is the effort on the part of county secretaries to interest the physicians in their areas in membership in the Society.

The report of the Society's finances is presented in full detail and from it we should all derive satisfaction. I know Dr. Gibson will discuss this report for you and I shall refer to but one item which reflects an operation of the secretary's office. It is the Annual Meeting Fund on page 28. The surplus of $10,280.05 represents the profits accumulated from our Annual Meetings during the past few years. After paying all of the expenses incident to the meetings, $1,501 was added to the surplus in 1951. Because our meetings have developed and are attended so enthusiastically, an increasing number of commercial exhibitors seek to show their products with us and this year, although we have more space than usual, we could not accommodate all who wished to participate. Nevertheless, this meeting will perhaps be the most profitable we have had.

There is no report of the AMA dues transaction in the Treasurer's Report before you. These funds are not considered as the property of the Society since we serve only as agent for the American Medical Association and accounting for them is not included in the Society's financial statement. Your attention is directed particularly to the last sentence of the next to the last paragraph of the accountant's state-

ment on page 28. This notation regarding bonding was made by our accountant at my request. I believe it is improper practice on the part of the AMA to permit the handling of large sums of its money by hundreds of persons throughout the country without the protection of fidelity bonds. In 1951, the secretary's office collected $51,525 of 1951 dues for the AMA and to this was added a few thousand dollars of hold over payments for 1950. For this service the Society received $511.38 from the AMA which covered only a part of the cost to the Society. Our bookkeeping staff informs me that it takes about twice as much time and activity to collect the AMA dues as to collect our own state and county dues, the reasons being the large amount of correspondence necessary to straighten out misunderstandings and to maintain the complicated records that are required. There will be added confusion this year because of the new regulation that AMA dues must be paid before June 1 if one wishes to remain a member of the Association. I cannot advocate too strongly that the AMA collect its own dues through the Chicago office and do away with the hundreds of county and state collection points and dozens of different billing methods and accounting procedures. 2,061 members of the Society actually paid their dues to the AMA in 1951, this was 75.5 per cent of the membership. There were 195 members exempt from payment for numerous acceptable reasons making a total of 2,256 Connecticut members in good standing, or 82.7 per cent. We do not know how this compares with the record for other states because the AMA does not disclose these figures.

New efforts on the part of the county associations to improve their operation and increase their services have been noteworthy during the past year. Hartford County has taken the lead with a substantial increase in dues and the employment of a full time executive secretary. Mr. Gordon has approached his new assignment with ability and zeal and all of us in the state office are pleased to have him here and we will do everything we can to be of assistance to him and the Association's program. Fairfield has made steady progress during the past few years and in 1951 more than doubled its dues to expand its public relations program and stimulate member interest in meetings. The New London County Association holds monthly meetings with scientific programs through most of the year and Middlesex County is taking a deep interest in community medical service. Emergency call services have developed widely and ten are now in operation in the towns of Bridgeport, Danbury, Greenwich, Norwalk and Stamford in Fairfield County, Hartford, Manchester and New Britain in Hartford County and in Torrington and Norwich. Interesting developments in this field are anticipated in New Haven. All of this is most encouraging. It was not unexpected that during the recent years the county associations would unconsciously leave some of their responsibilities to the expanding State Office, but in truth our strength lies in the county organizations and the State Society should only complement them by serving as an integrating influence and doing those things that must be done at the state level.

Two rather unusual and interesting developments have occurred during the year, one of economic significance and the other quite sentimental. First, the Society offered its members group insurance against the cost of prolonged illness. To our knowledge, this is the first time such a contract has been offered to a professional organization and indeed, insurance of this kind is not common. The response on the part of the membership has been fair and the group went into operation on April 15. It is expected as time goes on and the benefits provided are better understood that the group will grow substantially as did the Society's health and accident insurance which was started 15 years ago.

A year ago, your secretary suggested to some of the members of the ambitious Auxiliary that we would like to collect pictures of all of the past presidents of the Society. This valuable job was undertaken by Mrs. James D. Gold of Bridgeport and she accomplished a great deal in a very few months. Since last fall, we have been helping Mrs. Gold from the State Office and it is almost unbelievable the success we have had. 114 physicians have served as president of the Society during the last 160 years. In the earlier days, the presidents seemed to be more durable and served more than one year, indeed, the second president served for seven years. We now have pictures of all but twenty-seven of these 114 distinguished gentlemen and additional ones are being found every now and then. I wish to express the Society's appreciation of the effort and thoughtfulness that has been given by so many, particularly the members in Hartford County, its list is complete. I am grateful also to Daniel Sullivan of New London and that great Litchfield County antiquarian, Charles Turkington. Finally, I believe these portraits will be displayed in panels in the Society's building.

Arranging this meeting and working with the local committee under the Chairman, Dr. Cullen, and the Program Committee of which Dr. Leonard is the chairman, has been a pleasure. Things have gone smoothly in every way and I know these three days will give ample evidence of the care and effort that these committees have put into this job and the fine cooperation they have received from the staff of this school.

You have before you well prepared reports of the committees of the Society and I shall make but little comment on them, as you read them and discussion unfolds during the day, I am sure you will be impressed with the wide importance of the Society in your lives and in the public service. There is some unfinished business, there always will be, but this year I hope that the start which has been made at conferences between our Committee on Hospitals and representatives of the State Hospital Association will continue. There is an increasing number of hospital staff and administration questions that can be best understood in a conference group of this kind. I also think that our Committee on Chronic Illness should intensify its activities giving new attention to the economic loss resulting from prolonged illness and the Conference Committee with the State Dental Association needs to realize its importance and establish itself as a useful and significant agency of the Society. These are some of the things that we could do better than we are doing, but we have the spirit and the ability to do them well and I believe we will.

Wanted

We are still searching for missing pictures of past presidents. There have been 114 presidents of the Society in the past 160 years and pictures of all but the following are now in the Society files. Some member must have a clue about all of these. Will you help us?

1792 Leverett Hubbard, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1829 John S. Peters, Hebron
1832 William Buel, Litchfield
1834 Thomas Minor, Middletown
1837 Silas Fuller, Hartford
1843 Luther Ticknor, Salisbury
1851 Rufus Blakeman, Greenfield
1853 Richard Warner, Cromwell
1865 Nathan B. Ives, New Haven
1866 Isaac G. Porter, New London
1867 Charles Woodward, Middletown
1870 Charles F. Sumner, Bolton
1873 Ira Hutchinson, Cromwell
1874 Lowell Holbrook, Thompson
1878 Charles M. Carleton, Norwich
1879 Alfred R. Goodrich, Vernon
1880 Gideon L. Platt, Waterbury
1882 William G. Brownson, New Canaan
1883 Elisha B. Nye, Middletown
1885 Elijah C. Kinney, Norwich
1893 Francis D. Edgerton, Middletown
1895 Seth Hill, Stepney
1899 Charles S. Rodman, Waterbury
1905 Edward H. Welch, West Winsted

Meetings Held in April

April 2—Executive Committee, Blue Cross
April 4—Selective Service Advisory Committee
April 9—Committee on Hospitals
Clinical Congress Committee
April 14—Annual Meeting Arrangements Committee
April 15—Special Committee on State Welfare Department
April 16—Industrial Health Committee
Council of New England State Medical Societies
April 17—Public Health Committee
April 18—Governor's Conference on Mental Health
April 19—Clinical Congress Committee
April 24—Board of Directors Blue Cross
April 29—House of Delegates

New England Health Institute Preliminary Program

One hundred and sixteen speakers will participate in the three-day program of the 18th New England Health Institute June 18-20 at the University of Connecticut at Storrs.

Fifty-one physicians will present clinical lectures and participate in symposia, according to the preliminary program published in the April issue of the Connecticut State Health Department Bulletin.

General topics will comprise Medical Facilities and the Older Worker—Water Supplies, Including Fluoridation—Health Education—Mental Hygiene and Civil Defense—The Handicapped Worker—Tuberculosis—Home Accident Control: The Community Approach—The Mental Hygiene Clinic in the Community Health Program—Rehabilitation of Medically Handicapped Workers for Gainful Occu-

pation—Child Health—Nutrition—Community Control of Chronic Diseases—Maternal Health—Voluntary Health Insurance—Veneral Disease Control—Town Meeting for Health—Hearing Loss—Disease Control Measures—Better Use of Public Health Nursing Facilities in the Community—Virus Diseases—Planning for the Care of the Patient—Dental and School Health Programs—The Office Wheels of Health Agencies.

A large attendance is anticipated for the three-day event and because of limited room accommodations the committee urges that reservations be made as early as possible. A reservation form is included in the program published in the April Health Department Bulletin.

New Members

NEW HAVEN COUNTY

Michael D. Albis, Hamden
William G. Banfield, New Haven
Roger W. Cooper, Waterbury
Gabriel N. Cusanelli, New Haven
Michael S. Erba, New Haven
Doris C. Grosskreutz, New Haven
Walter Igersheimer, New Haven
Louis J. Micheels, New Haven
William P. Nelson, New Haven
William L. Pious, New Haven
Maurice E. Turcotte, Meriden
Henry Wexler, New Haven
Robert P. Zanes, New Haven

HARTFORD COUNTY

William K. Bannister, Hartford
Harold S. Barrett, Hartford
Freeman F. Brown, Jr., Hartford
James L. Callahan, New Britain
Enrique Delgado-Fourzan, Hartford
Michael Eilbergas, Windsor Locks
Theodore Goldstein, Hartford
Thomas McL. Healy, Manchester
David D. Hershey, Bristol
Robert Hunter, Hartford
Leonard M. Lasser, Hartford
Frank J. Leo, East Hartford
Wladimir T. Liberson, Hartford
James F. Loftus, Hartford
Irwin T. Mancall, Hartford
Alexander Marsh, Hartford
Richard E. Nicholson, Hartford
D. Sergeant Pepper, Hartford
Douglas D. Perry, Bristol
Edward C. Porter, Hartford
Edward J. Sennett, Hartford
Robert J. Vernlund, Hartford
William J. Welch, East Hartford

NEW LONDON COUNTY

Bezaleel H. Griffith, New London
George W. Wood, III, Norwich
Joseph T. Murray, New London
Charles M. Suttles, Norwich

FAIRFIELD COUNTY

Alan B. Adam, Stamford
Phil L. Barringer, Danbury
Armand G. Bineua, Greenwich
Morton S. Biskind, Westport
Charlotte R. Brown, Norwalk
Roger P. Castro, Danbury
Joseph B. Cherry, Danbury
John P. Colmore, Noroton Heights
Henry R. Corwin, Westport
Marie J. Fakkel, Stamford
William A. Jarrett, Newtown
Marshall Mandell, South Norwalk
Harold T. McDonald, Jr., Stamford
Saul B. Meltzer, Bridgeport
John L. Meunier, Danbury
John J. Nolan, Stamford
James M. O'Brien, Bridgeport
Martin Schultz, Westport
Elwyn M. Smolen, Fairfield
Harry L. Trambert, Norwalk

President's Committee Will Honor Physician

A Physician's Award will be given annually by the President's Committee on employment of the physically handicapped to a physician who has made an outstanding contribution to the employment welfare of the handicapped. Nominations for the award, an illuminated parchment scroll, signed by the President of the United States, will be made jointly by State committees on employment of the handicapped and State medical societies. In addition to the national award, the Committee will present citations for outstanding service to the physicians nominated by the various States.

THE HISTORIAN'S NOTE BOOK

DR. JOHN P. C. FOSTER 1847 - 1910
(A Pioneer in the Treatment of Tuberculosis and a Founder of Gaylord Farm Sanatorium)

William H. Carmalt, M.D.

John Pierrepont Codrington Foster, the first to use tuberculin in America and a founder of the National Association for the Study and Prevention of Tuberculosis, was born March 2, 1847 in New Haven, where he lived nearly his whole life, dying there April 1, 1910. Of an ancestry identified with the best history of the city and colony, he could not be otherwise than intensely loyal to all that pertained to its welfare and good name. His education, preparatory to college, was at the Russell Military Institute. He was graduated from the academic department of Yale in 1869. Soon after he was attacked with pulmonary tuberculosis, necessitating a residence of several years in Florida. Feeling himself reasonably safe for a life in the North, he returned to New Haven, studied medicine at the Yale Medical School, was graduated M.D. in 1875 and at once began the practice of his profession.

In 1877 he was appointed instructor of anatomy as applied to art, in the school of fine arts in Yale University, a position he held, with great satisfaction to his pupils, until his death.

The early part of his professional career was largely among the students of the University; the necessity of some kind of a hospital for them so impressed itself upon him that he advocated in the most strenuous way such an addition to the University equipment. The present Yale Home and Infirmary is the result of his influence upon the friends of the college and upon the administration of President Dwight. It was a disappointment to him that its usefulness was so restricted by the unreasoning fears of some persons in the vicinity which prevented the admission to it of the milder forms of contagious diseases among students, who are still compelled to expose to infection their comrades in the college dormitories.

In 1879 he was appointed post surgeon to the United States Marine Hospital Service, holding the position until his death.

Early in his professional career Dr. Foster became intensely interested in the study of tuberculosis; he was the first physician in this country to use Koch's tuberculin, employing it in a case of pulmonary tuberculosis on December 3, 1890, having obtained the lymph through Professor Chittenden of the Sheffield Scientific School some time before anyone else had it in this country. His mind, however, was too broad ever to allow him to become a mere specialist for private practice; the large scope of the tuberculosis question impressed itself overwhelmingly upon him.

He was one of the founders of the National Association for the Study and Prevention of Tuberculosis, was director and a member of the executive committee and contributed a paper to the first meeting in 1905. His interest in the Association continued unabated until his death. He was also interested in the International Congress of Tuberculosis, was a vice-president of the Sixth Congress in the second Section on Sanatoria, Hospitals and Dispensaries.

The piece of work that interested Dr. Foster the most in his professional career and with which he was peculiarly identified, was the Gaylord Farm Sanatorium, near Wallingford in New Haven County, and the success of this was a matter of the greatest pride and gratification to him. The sanatorium opened in September, 1904, and was exclusively for persons in the early stages of tuberculosis, of very moderate means and residents of the State.

In common with all others engaged in the prevention of the spread of tuberculosis, Dr. Foster appreciated that the State must take part in the struggle and he instituted measures to bring the

From Proceedings of the Connecticut State Medical Society 1910, 316-320
The biographer Dr. Carmalt, was for many years professor of surgery, Yale School of Medicine

matter to the attention of the General Assembly and urge early action. Accordingly a commission was appointed, of which he was chairman, with the result that in 1909 a permanent commission was created, empowered to purchase sites, erect suitable buildings, appoint administrative and medical officers in three counties of the State, to be extended to others as the necessities demanded. Dr. Foster threw himself into the work with all his energies. He knew he was overtaxing himself, but the work was before him and he could not rest.

Never of a strong constitution, he had a sharp attack of pneumonia in 1898; with the relics of a former active tuberculosis in his system, the physical strain, the constant combatting of political antagonisms where he had anticipated support, the care of private patients, who depended upon him and who would not be denied, all contributed to use up his powers of resistance, so that when in March 1910, what at first was a comparatively limited lobar pneumonia rapidly extended to involve both lungs; a myocarditis developed to which he succumbed, as distinct a sacrifice to public duty as a soldier on the field of battle.

Expansion in Medical Education

A survey conducted by the *New York Times* recently showed the greatest expansion program in the history of medical education, to cost $250,000,000, is now underway in this country.

The *Times* surveyed 80 medical colleges and 48 state commissioners of education through questionnaires.

According to the survey, medical colleges will spend, within the next few years, $50,000,000 for laboratories, $30,000,000 for classrooms and $20,000,000 for dormitories. Another $100,000,000 is earmarked for research and special projects. In addition, the immediate cost for establishing new medical institutions will run above $50,000,000, making an over-all expansion program of a quarter of a billion dollars.

"To meet the increasing demands for more physicians and medically-trained men," the *Times* said, "at least 10 states have taken steps to build new medical schools or expand their two year basic science schools into four year institutions.

"In the current academic year—1951-52—the medical colleges admitted the largest freshman classes in recent history, a total of 7,381 . . . Despite the expansions now taking place, large numbers of qualified applicants are unable to gain admittance to any medical college in this country. Many of them seek places in foreign institutions. The records indicate that 20,000 individuals applied for admission to American medical schools for the current college year. As many of them applied to more than one institution, the total number of applications was more than 70,000, or an average of 3.5 a student."

Navy Accepts 108 for Intern Training

A total of 108 senior medical students who will graduate from various medical colleges and schools throughout the United States in 1952 have been accepted for intern training at U. S. Naval Hospitals beginning July 1, 1952 under the Navy's Graduate Medical Training Program.

The students will be appointed Lieutenants (junior grade) in the Medical Corps, Naval Reserve, following graduation and will then be ordered into the active military service and assigned to Naval Hospitals approved for intern training by the American Medical Association Council on Medical Education and Hospitals.

Connecticut will be represented in this group by William H. Baird of Fairfield and John G. O'Hurley of Wethersfield, both assigned to the Naval Hospital at Chelsea, Massachusetts.

'52 Funds Approved for Medical Education Survey

A $39,650 budget to wind up activities of the Committee for the Survey of Medical Education has been approved by the AMA Board of Trustees. The Committee reports that Survey findings should be completed and sent to the publisher by June, 1952.

A representative sample of 41 medical schools was studied with the idea of pointing up the basic problems facing medical education today. Broad objectives of the Survey are: (1) to improve medical education to meet over-all health needs of the public; (2) evaluate the degree to which medical schools are meeting the need for physicians; (3) promote the advancement of medical science, and (4) inform the public of the nature, content and purposes of medical education.

6,135 PHYSICIANS

America's medical schools graduated 6,135 new doctors of medicine last year.

More than $13,000 was spent to train each of them — and most of this was added to the operating deficit.

The medical profession is helping to meet this challenge through the American Medical Education Foundation.

A fund-raising committee represents the Foundation in Connecticut. If you have not already contributed, you may use the coupon below to obtain a pledge card and information concerning this important activity.

Medical Education Needs Your Help

Edward J. Whalen, M.D., President
Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send me a pledge card and information concerning the American Medical Education Foundation.

Name .....

Office Address .....

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
John E. Flaherty, Rockville
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

New Emergency Call System in Danbury

The Danbury Medical Society on March 15 inaugurated a new 24 hour emergency medical call system for residents of that city and adjacent communities.

The system is being operated through a commercial telephone answering service. Its operation is supervised by a committee of the local Society and a panel of physicians has been organized to accept emergency calls on a rotating basis. In announcing the new service, officers of the Society urged that residents use it only for genuine emergencies.

The Danbury service is the eleventh new emergency plan in Connecticut. Initiated in cooperation with the public relations program of the Fairfield County Medical Association, it represents the fifth principal community in that county to offer residents an emergency call service sponsored by a medical organization.

Other Fairfield County communities in which these plans are operating include Bridgeport, Stamford, Greenwich and Norwalk. Emergency plans in other sections of the State have been established in Hartford, New Britain, Manchester, Torrington, Norwich and Putnam.

President Cline Urges Community Action

Dr. John W. Cline, president of the American Medical Association, strongly urges medical organizations to develop positive programs of community service to win and retain public good will.

Writing in the March 29 issue of the *Journal A. M. A.*, he states the case for community action as follows:

"While individual physicians cannot seek favorable publicity, medical societies can publicly take credit for good performance. When a medical society is an active public service organization, it can successfully raise the prestige of the total local medical profession. I therefore strongly urge every society to establish a positive public service program. Do this and then tell your community about it. In establishing such programs, we must always keep before us the key to successful public relations. This is the knowledge that in order to win and retain public respect it must be deserved."

The message is part of a two page report concerning the planning and operation of the American Medical Association's expanded public relations program.

Middlesex County Plans Service Booklet

Acting on the premise that authentic information is a sound step toward improved relationships, the Public Relations Committee of the Middlesex County Medical Association is planning publication of a booklet outlining the Association's activities and services.

The committee was authorized to start planning for the publication at the recent annual meeting of the Association. In presenting the proposal, Dr. Harry C. Knight, committee chairman, said the booklet will be designed "to tell what the County Medical Association means to the public and how medical facilities can be used most effectively."

The booklet is to be made available for distribution through Chambers of Commerce and other community organizations.

Review Committees Operating in 42 States

Committees of state and county medical associations to review patients' complaints are now functioning in 42 states, according to a recent report by the American Medical Association's Council on Medical Service.

The committees range in size from three to 15 members, with committees of five members predominating, the report states. Tenure of office is from one year to terms of indefinite length, although most committees limit membership to five years or less.

Jurisdiction of the committees, for the most part, is limited to arbitration, cases requiring disciplinary action being referred to proper medical judicial authorities. Few of the committees accept verbal complaints, but all accept those in writing, while several committees are authorized to initiate investigation when considered justified, whether or not a complaint has been filed.

The organization of the Committee on Professional Relations of the State Medical Society is outlined in the report, which contains similar information concerning other state committees and notes on operational procedures. Copies of the 23 page report are available through the office of the State Medical Society.

New Radio Recordings

A series of 13 new recordings for use by medical societies over local radio stations has been released by the Bureau of Health Education of the American Medical Association.

Titled "Interlude," the series presents the music of 13 composers of 75 to 100 years ago, together with descriptions of health problems of those days and ills of the composers themselves as contrasted with present health conditions.

The program time of each recording is 14½ minutes, thus permitting 30 seconds for a message by the medical association sponsoring the series. Sets of the recordings can be obtained on loan, without charge, through the Public Relations Section of the State Medical Society.

County Officers' Conference

When the activities of a medical association engage the interest of only a small minority of its members, the cause often involves much more than apathy, according to Rollen Waterson, executive secretary of the Alameda-Contra Costa Medical Association, Oakland, California.

Guest speaker at the State Medical Society's March 20 Conference of County Officers, Mr. Waterson declared the lack of participation usually attributed to apathy may be rooted in feelings of aggression and hostility.

"Forget the word apathy," he said, "it doesn't apply."

The speaker cited results of a survey among members of his own association in which seeming apathy was found to be a result of beliefs that a small minority conducted association affairs without interest in widespread participation.

"We found considerable hostility and aggression in these relationships," he declared, and related how the situation was improved through an organized program to stimulate member interest and participation.

Approximately 50 county association officers and members of committees on public relations, postgraduate education, and emergency medical service attended the afternoon and evening sessions of the conference, held at the New Haven Medical Association auditorium.

Brae Rafferty, Society president, was presiding officer and objectives of the conference were outlined by Joseph H. Howard, chairman of the Society's Council.

Conference topics included Balancing the Books for Medical Education—Is the Clinical Congress Meeting Physician Needs?—Civil Defense Medical Planning in Connecticut—County Medical Associations and Connecticut Medical Service—Your Medical Association and the People.

Physician speakers were William G. H. Dobbs, Torrington; Hugh L. Dwyer, New Haven; Sidney S. Quarrier, Hartford; Eugene J. Fitzpatrick, New Haven; Milton M. Lieberthal, Bridgeport; Albert S. Gray, Hartford; Thomas J. Danaher, Torrington; Alfred L. Burgdorf, Hartford; Walter I. Russell, New Haven; Thomas M. Feeney, Hartford; F. Erwin Tracy, Middletown; Oliver L. Stringfield, Stamford; Burdette J. Buck, Hartford; and Harry C. Knight, Middletown.

AMA Pays $20,000 in '52 for Chronic Illness

The AMA has pledged continued financial support to the Commission on Chronic Illness in the amount of $80,000 to be paid over a four year period. The Commission, an independent national agency, is conducting an intensive study of chronic illness—one of the most important health problems in America today. This year's installment of $20,000 was recently turned over to the Commission. A $300,000 budget set by the Commission for the coming four year period has been met by twelve contributing organizations.

NEWS FROM WASHINGTON

VA Increases Collections on Non Service Connected Cases

Although still having trouble making collections, Veterans Administration reports it obtained $1,213,-251 from outside sources for treatment of hospitalized non service connected cases in the last six months of 1951. This is almost as much as was collected on these accounts in the previous 12 months.

Most money came from workmen's compensation boards, which VA described as the "most cooperative" of the insurers. The agency also made efforts to collect from prepaid medical and hospital care programs and insurance companies, but these generally refused payment, arguing that VA is not entitled to collect on the policies. The increase in total collections was attributed largely to the fact that more veterans are being employed in industries under jurisdiction of workmen's compensation boards.

According to a VA legal official, the administration is handicapped in collections by a number of factors:

1. VA bases its claim on an administrative interpretation, not a specific law, and does not want to sue insurers until it has a better legal position.

2. "Exclusion clauses" being inserted in more and more policies prohibit payment to tax supported institutions, such as federal and state hospitals.

3. Insurers argue that their policies are non assignable, and therefore that when a veteran assigns his policy to VA, the action is not binding. The claim is also advanced that because VA cannot legally collect from the individual, it is not entitled to collect from the insuring agency.

VA makes no attempt to collect on policies carried by service connected cases. On non service connected cases, it maintains that the veteran signing the "pauper's oath" makes himself eligible for free hospitalization only for the amount in excess of his hospitalization insurance benefits.

ODM Panel Will Promote More Efficient Use of Nurses in Hospitals

A special panel on hospitals and nursing, which will be set up shortly by the Office of Defense Mobilization, will concentrate on perfecting techniques for the more efficient use of nurses and on convincing hospitals that the new techniques should be adopted. An ODM spokesman, outlining objectives of the new subcommittee, said it also will do all it can to promote recruitment of various categories of nurses now in short supply.

The program being worked out for the subcommittee calls for a study of various methods devised by individual hospitals to spread the available supply of qualified nurses while at the same time maintaining a high standard of patient care. Most promising of the ideas will be tried out in other hospitals and the results carefully observed. Then the subcommittee will attempt to induce hospitals facing nurse shortages to adopt techniques which have been found to promote efficiency without sacrificing patient care.

The group, full membership of which will be announced in a few weeks, will function under Dr. Howard Rusk's Health Resources Advisory Committee of ODM.

Specific Substance Found for Use Against Radiation

Dr. Shields Warren, director of Atomic Energy Commission's Division of Biology and Medicine, reports that a specific substance has been found to work against radiation poisoning and that the discovery is of "very real significance." In testimony before the House Appropriations Committee, Dr. Warren said it has been determined that an emulsion of bone marrow will protect experimental animals against radiation, and added:

"The material in itself is not so important as the fact that one gets protection. That is, the bone marrow itself is not so important as the fact that you can get protection by the substance that is formed there. This is an injection from which we ought to be able to get a specific chemical substance that can be used here. This is the same sort of scientific lead as was the failure of bacteria to grow on mold-contaminated plates, when the initial discovery of penicillin was being foreshadowed. It is very early in the process, but this is the first time a specific sub-

stance has been found which will work against radiation."

8,000 With Eye Disabilities Rehabilitated

U. S. Office of Vocational Rehabilitation reports rehabilitation and employment of more than 8,000 persons suffering eye disabilities during the last fiscal year. Three thousand were blind and one in ten of the group had never worked prior to rehabilitation. Since the start of the federal-state vocational rehabilitation program in 1943, about 48,000 persons with visual impairments have been rehabilitated to the point where they can be employed.

Eyeglass Rebates to Physicians Upheld by Supreme Court

In a decision handed down March 10, Supreme Court upheld legality of opticians sharing eyeglass profits with prescribing physicians, at least under circumstances that existed in case under consideration. It involved two North Carolina optical firms, under common ownership, which in 1943 and 1944 "kicked back" to doctors one-third of the retail price of glasses. They deducted these rebates as business expenses and were challenged by Bureau of Internal Revenue. Thomas B. Lilly and Helen W. Lilly lost their case in Court of Appeals but the recent Supreme Court decision justified the payments as ordinary and necessary and which violated no public policy. Tax deficiencies involved totaled $124,107.

PHS Asks $200,000 Extra for Clinical Study of TB Drugs

At instance of Public Health Service, President Truman sent a special communication to Congress Wednesday requesting an additional fund of $200,000 for clinical investigation of isonicotinic acid derivatives in treatment of tuberculosis. Program calls for 18 month study of 1,500 patients in 15 hospitals and sanatoria in Tennessee, Michigan, Ohio, Washington, Massachusetts, Minnesota, Pennsylvania, New York, District of Columbia, Georgia, Florida, North Carolina and Connecticut. Budget breakdown: drugs, $100,000; x-rays, $20,000; salaries and consultants' fees, $45,800; tabulating costs, $20,000; two fulltime Public Health Service positions, $11,000; miscellaneous, $3,200.

Senate Appropriations Committee, now processing PHS budget, is likely to grant the request—but not as an additional appropriation. Rather, it may order PHS to get the necessary money by "borrowing" it from research and technical assistance categories that come under head of assistance to states for control of tuberculosis. But PHS says a separate $250,000 already has been trimmed from those earmarkings in order to help finance this large scale hydrazide investigation and to make additional cuts on other state assistance projects would be unwise.

New House Legislation

HR7022—Veterans Presumption of Service Connection for Non Pulmonary Tuberculosis. By Mr. Adair, of Indiana, March 12. To amend veterans regulations to establish for persons who served in the Armed Forces during wartime a further presumption of service connection for non pulmonary tuberculosis. Referred to the Committee on Veterans' Affairs.

Comment: The present regulations do not establish a three year presumption of service connection for non pulmonary tuberculosis. This bill would amend the regulation so that non pulmonary cases would have the benefit of a presumption of service connection. This bill was introduced at the request of Veterans of Foreign Wars.

HR7031—Veterans Presumption of Service Connection for Polio. By Mr. Price, of Illinois, March 12. To amend the veterans regulations to establish a conclusive presumption of service connection for poliomyelitis becoming manifest within one year after separation from active wartime service, or service after June 26, 1950. Referred to the Committee on Veterans' Affairs.

Comment: This bill would amend the veterans regulations to provide that persons who serve in the military services for 90 days or more and contract poliomyelitis shall be conclusively presumed to have incurred such disability in actice service when it is shown to exist within one year after separation from active service.

HR7042—Income Tax Deduction for Medical Expense. By Mr. Morano, of Connecticut, March 12. To amend section 23 (x) of the Internal Revenue Code to increase the maximum allowable deduction for medical expenses. Referred to the Committee on Ways and Means.

Comment: Bill seeks to amend the present law permitting deduction from income subject to taxation

by increasing the maximum allowable deductions from $1,250 per person to $1,875 and increasing the maximum in the case of a joint return of husband and wife to $7,500. Deductions are presently permitted for that portion of medical expense which exceeds 5 per cent of gross income.

HR7347—Veterans Presumption of Service Connection for Non Pulmonary Tuberculosis. By Mr. Rankin, of Mississippi, April 1. To amend the veterans' regulations to establish for certain persons who served in the Armed Forces a further presumption of service connection for non pulmonary forms of active tuberculosis. Referred to the Committee on Veterans' Affairs.

Comment: This bill, similar to HR7022, would amend Veterans Administration regulations to establish for persons who served in the Armed Forces during wartime a 3 year presumption of service connection for non pulmonary tuberculosis. The present regulations establish a one year presumption of service connection for non pulmonary tuberculosis for World War II veterans. This bill was introduced at the request of the American Legion.

Action

HR910—Federal Aid to Nurse Education. The House Interstate and Foreign Commerce Committee during a third closed-door meeting on March 18 voted to table this bill.

HR4528—Prohibiting transportation of fireworks into any state in which the sale of such fireworks is prohibited. The House Committee on Judiciary favorably reported this bill to the House floor on March 3.

Senate passed HR1043, authorizing hospitalization of non Indians in Indian hospitals on a fee basis; HR1739, giving financial relief to Hawaii for care of leprosy patients, and S2552, enabling armed services to commission women physicians and dentists on equal basis with men. HR1043, passed by House last July, was sent to White House for signature. HR1739 was amended by Senate and will require House concurrence. Favorable House action on S2552 is anticipated.

Rehabilitation at New High

Ewing also submitted annual report of Office of Vocational Rehabilitation, prepared by Director Mary E. Sqitzer. Document says 80,000 disabled men and women were started on self sustaining jobs during fiscal year 1951 through cooperative efforts of state and Federal governments. This was an all time high in program's 31 year history, comparing with 71,500 in 1950, when a new record was set. Last year's operations cost $21 million in Federal funds and $9.2 million in state contributions.

Two Year Program to Improve Medical Certification Proposed by PHS Group

The U. S. Public Health Service Conference on Records and Statistics has sent to its members for ratification a proposal that all states make a concerted drive during the next two years to improve medical certifications of cause of death. The Conference proposes that this be done through "intensive querying, through extensive showing of the film strip on medical certification of cause of death and through other informational means." Local health officers would be asked to bring to the attention of county medical societies and hospital staffs the proper procedure of certifying causes of death. The Conference, sponsored by the PHS, has been meeting here in annual session.

Also up for ratification by members is another recommendation that the present fetal death certificate be studied for basic revision within the next two or three years. Among the suggested revisions is that the term "fetal death" replace "stillbirth" in reports and on certificates. As an interim procedure, it is suggested that the term "stillbirth" be used parenthetically when necessary.

The conference is made up of state registrars and public health statisticians. Medical societies and individuals may procure copies of a 32 page conference publication, *Records at Work*, by writing to the conference secretary, Dr. Halbert L. Dunn, c/o National Office of Vital Statistics, Public Health Service, Washington 25, D. C.

Ewing Report Urges Bigger U. S. Role in Health Field

Annual report of Social Security Administration has been filed by Commissioner Arthur J. Altmeyer and submitted to Congress and President Truman by FSA Administrator Ewing. Among its recommendations: Institution of national health insurance, dis-

ability insurance and hospitalization insurance benefits for persons over age 65; increased Federal financial aid for school health services; fluoridation of community drinking water as a caries-reduction measure; reinstatement of World War II program of government assistance for maternity and infant care in servicemen's families. Most immediate need is held to be extension of social security coverage to members of the armed forces.

The Ewing-Altmeyer report restates Administration position that growth of prepaid health plans only points up feasibility of adopting insurance principle on a universal, compulsory basis; that hospitalization insurance for the aged is a pressing need, and that disability insurance would increase number of persons rehabilitated for occupational productivity and reduce public assistance burden. "Voluntary insurance plans are no substitute for national health insurance operated as part of a comprehensive social insurance program," the report says. "All voluntary medical care insurance, non profit and commercial, provided protection against only about 12 per cent of private expenditures for medical care in 1950."

Reed - Keogh Bill

The Reed-Keogh bill, a voluntary pension plan for self-employed professionals, is now pending in the House of Representatives.

"Under the terms of the bill, the Federal Internal Revenue Code would be amended to enable self-employed professional persons and some employed persons to exclude from current taxable income amounts sufficient to finance a reasonable retirement annuity. They would, of course, have to declare the annuity as it is received during their retired years as taxable income."

This bill, now being heard by the House Ways and Means Committee, has the support of the American Medical Association, the American Bar Association and the American Dental Association.

It should have your individual support too. Follow the progress of the Reed-Keogh bill and urge your Congressman to help its passage. Sit down today and write him a letter, telling him how vital such protection is to you—when your earnings capacity has declined in your late years and when you should be eligible for some sort of annuity as are millions of other Americans.

New Health Records in 1951

New low records were established in Connecticut in 1951 for infant and maternal mortality and death rates for tuberculosis and appendicitis according to reports from the Connecticut State Department of Health.

Infant mortality for 1951, 20.8 deaths under one year per 1,000 live births, set a new record for the State for the sixth successive year. Based on the experience of ten years ago when the rate was 31.0, 1,313 babies would have died instead of 879 actually recorded. This represents a saving of 434 lives in 1951 alone. The steady progression of lower infant mortality rates gives as yet no indication that a minimum has been reached; further savings of infant lives appear probable in future years. There were only 6 maternal deaths in 1951 compared to 18 during the previous year. The resulting rate, 0.1 per 1,000 live births, was the lowest recorded to date anywhere and represents an extraordinary achievement on the part of Connecticut physicians, hospitals and public health workers; no other figure in recent vital statistics literature approaches it.

The tuberculosis death rate, 14.1, showed improvement over the preceding year. The 1951 rate was less than one half that prevailing as late as five years ago. The appendicitis death rate, 1.3, set a new minimum for the eighth successive year.

The one unfavorable development of the year was the rise in the death rate for pneumonia and influenza. Pneumonia mortality rose appreciably above the level of the preceding two years and the rate, 18.3, approached that for 1948. Influenza was prevalent in the State during the early months of 1951 and the death rate for influenza, 2.3, was the highest since 1944. This, no doubt, had some bearing on the rise in pneumonia mortality.

Dr. Powers Honored by Yale Journal

The February 1952 issue of *The Yale Journal of Biology and Medicine* is designated The Grovers Francis Powers Number. It is a fitting tribute to the former professor of pediatrics at Yale and contains a variety of articles on various phases of pediatric practice written by former members of Dr. Powers' house staff. Due to Grover Powers "it is probably no exaggeration to state that a higher proportion of Yale students have expressed an abiding interest in pediatrics than those from any other school."

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Policies and Procedures Adopted by the Department of Defense in Implementing Public Law 779, 81st Congress

At the outbreak of the Korean incident, the only source of physicians and dentists available to the military services, other than those already on duty, was the reserve components. At that time the rolls of the active and inactive reserve components of the Army could not supply sufficient medical and dental officers, particularly in the junior grades. Only a very small number of medical and dental ASTP participants had enrolled in the Army Reserve. The Navy, on the other hand, was in a much better position because the majority of the medical and dental participants in the V-12 Program were members of the Naval Reserve. The Air Force was in a position similar to that of the Army, with the exception that it was not an independent department during World War II and, therefore, had not sponsored an educational program.

To insure an adequate number of physicians and dentists to meet military requirements, Public Law 779 (the Doctor Draft Act) was enacted. Under its provisions members of reserve components were specifically exempted from registration by the following:

"Section 4i(1) . . . No such person who is a member of a reserve component of the Armed Forces shall, as long as he remains a member thereof, be liable for registration and induction under this subsection, but nothing in this subsection shall be construed to affect the authority of the President under any other provision of law to call to active duty members and units of the Reserve Components."

The effect of relieving members of reserve components from the obligation to register exempted all participants of the Navy V-12 Program, who were members of the Navy reserve component. This comprised a large group of physicians and dentists who would have been members of the Priority I group if they had not been so exempted. Further, in the Section quoted, specific authorization to call reserve personnel to active duty is reaffirmed and this is interpreted as indicating the intent of Congress that members of reserve components be so utilized at the discretion of the President.

Extensive and earnest study was given to the most equitable and satisfactory method of bringing physicians and dentists to active duty from the increased sources that became available after the enactment of Public Law 779. It was believed, and it still is believed, that the interests of all concerned are best served by the program which was adopted and which has been followed. It consists of assigning a priority classification, paralleling that of Selective Service, to all reserve medical and dental officers which they would have had under Selective Service had they not been exempt from registration and then calling them to active duty in accordance therewith. Thus, Priority I type reserves which includes Priority I registrants who have indicated a willingness to accept commissions are called up before Priority II's are called. It permits the Navy to utilize its reserves who were obligated to serve and it insures that the Army and the Air Force will have sufficient personnel. It also has the advantage of reducing to a minimum the necessity of actually drafting doctors by affording those who are vulnerable the opportunity of accepting commissions rather than having to face the stigma of being inducted involuntarily.

As the plan has operated, the Navy up to the present time has filled its requirements from its reserve components. The Air Force, with few exceptions, has had a sufficient number of requests for commissions and voluntary applications for extended active duty from Priority I registrants to meet its needs. Except for one month, July 1951, the Armed Forces has been able to fill its requirements for physicians by involuntarily ordering to duty Priority I registrants who have indicated a willingness to accept commissions.

You are well aware of the advantages to the interests of the national welfare in having the local and State Advisory Committees of the Selective Service

System advise the military departments on the essentiality of reserves destined for calls to duty. This arrangement has proved its merit and the departments have cooperated with it in a satisfactory manner even though the obligation to do so in the cases of reserve personnel is not prescribed under the provisions of Public Law 779.

It is true that there are some recalcitrant Priority I registrants who refuse to accept commissions and are escaping duty as long as a sufficient number to meet the requirement do volunteer. Their number, however, is relatively small. According to Selective Service statistics for January 31, 1952, of an original 10,785 Priority I living registrant physicians, 1,094 remain immediately available; and of an original 3,928 Priority I registrant dentists, 620 remain immediately available. Since January 31, 1952, the available Priority I dentist pool has been reduced by the induction calls for 335 dentists in April 1952 and 175 dentists in May 1952.

When all Priority I type reserves have been called to active duty, or deferred for acceptable reasons, the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called up. It is anticipated that this will occur within the next six months; hence, the recalcitrant ones are only delaying their service until all the Priority I registrants who have accepted commissions are called up. It is a matter of opinion whether this is to their advantage. If the military emergency should cease to exist before they are inducted, they will have escaped military duty. On the other hand, if the emergency continues, they will be forced to come into service at a later date and will have to serve after their more willing contemporaries are returned to civilian life and become reestablished in their practices.

It has been the desire of the Department of Defense to comply with the intent of Public Law 779. It is believed that as far as practicable this has been done to the best interests of the individuals and of the Armed Forces.

New Effort Under Way to Get Priority I Physicians to Join Reserves

A new effort is being made to induce about 1,000 physicians rated in Priority I of the doctor draft to sign up for service in the military reserves. Men involved were educated at government expense during World War II or deferred from service to continue their medical educations, but so far have not applied for reserve commissions.

National Advisory Committee to Selective Service (Dr. Howard A. Rusk, chairman) declares: "Various state committees, as well as the National Committee, have been deeply concerned over these individuals who did not at the time of special registration apply for a commisssion and have not subsequently done so while other more willing individuals have accepted commissions and many of them are now serving in the armed forces."

Selective Service Director Louis B. Hershey says these "inequities" can only be prevented by calling up physicians through Selective Service (not the reserves).

The acting chairman of Defense Department's Medical Policy Council, Dr. Melvin A. Casberg, warns: "When all Priority I type reserves have been called to active duty . . . the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called. It is anticipated this will occur within the next six months. Hence, the recalcitrant ones are only delaying their service until all Priority I registrants who have accepted commissions are called up."

Meanwhile, Defense Department has announced that 257 medical reserve officers will be called to active duty in July. Included will be 232 physicians. All are Priority I type reserves and will serve for two years.

Senate Approves Sliding-Scale Pay Increases for Uniformed Services

After voting down a series of amendments by Senator Douglas (D—Illinois) designed to reduce incentive and hazard pay bonuses, the Senate approved a cost of living increase for members of the uniformed services, including U. S. Public Health Service officers.

Just before the final vote, Senator Douglas dropped his plan to press for an amendment which would have cut off the $100 per month incentive bonus for physicians and dentists. Under present law this provision is scheduled to expire next September 1, with no officer eligible to qualify for the extra $100 after that date.

The Senate bill allows a 3 per cent base pay increase and varying increases in subsistence and housing allowances. Allowance increases would be

based on dependency status and rank, with lower ranking men receiving proportionately larger boosts. A conference will be required to work the bill into final form, because the House approved version carries a flat 10 per cent base pay increase, as well as 10 per cent in allowances. The bonus pay question probably will be before Congress in a different form later in the session. Defense Department officials now are working on a proposed extension of the law and will present it before September 1.

Army Calling 257 Medical and Dental Reserves to Duty

Army is in process of issuing active duty orders to 232 physicians and 25 dentists, also 8 veterinarians. All will be drawn from Reserve rolls, with the finger being placed only on doctors in Priority I–former ASTP's and V-12's who had no military duty subsequent to completion of professional education. Callups will be placed on two year duty status, commencing in July. "Physicians and veterinarians will be selected entirely from the Volunteer Reserve, but because of a shortage of dentists in this category it may be necessary to call some dentists from the Inactive Reserve," said Army announcement.

Return of Physicians to Civilian Life Gaining Momentum

Between now and June 1953, when doctor draft law is due to be terminated, Army alone plans to send back to civilian life nearly 3,000 reserve medical officers who were called to active duty following outbreak of Korean hostilities. Inasmuch as 24 months is maximum period of obligated duty, with 17 months the ceiling for those having previous military service and additional time being lopped off in each category in cases of those officers who served in Korea, separations are starting to get up a head of steam. However, they won't reach a peak for another three or four months. Army isn't worried about replacements–not only are there still more than 1,000 1-A's left in Priority I pool (exclusive of some 2,400 who are commissioned in armed forces but still untapped) but there will be a fresh crop of doctors completing internships this summer who, having received Selective Service deferment, thereby ripen into eligibility for military duties.

Barring World War III or an emergency that would necessitate development of military strength far above that projected for 1952-53 fiscal year, all signs are that physicians and dentists in Priorities III and IV won't feel breath of Selective Service. However, SS has begun taking steps preliminary to induction of Priority II dentists (pool of physicians in same category isn't expected to be touched before 1953). If and when II's are called up, there's better than an even chance that those who have had a year or more previous military service will have to put in only 12 months or so, instead of 17.

Casberg Relieves Lovelace on Defense Medical Council

Last year correspondent Gross (WRMS No. 234) forecast appointment of Dr. Melvin A. Casberg as deputy chairman of Armed Forces Medical Policy Council, noting probability of his early succession to chairmanship held by Dr. W. Randolph Lovelace, 2nd. Dr. Casberg was named and took office in January. Department of Defense disclosed resignation of Dr. Lovelace and announced Dr. Casberg as successor, effective April 1. Former had spent little time at his Pentagon desk since he took the job over from Dr. Richard L. Meiling last July and, in resigning, explained his professional duties at Albuquerque require his return to private practice. "You made a great personal sacrifice in this service and you have my most sincere gratitude and thanks," Dr. Lovelace was told by Secretary Lovett.

Dr. Casberg, son of a missionary doctor and former dean of St. Louis University School of Medicine, is a personable new bureaucrat who has actually been running the Council since first of year. He has the equipment to return AFMPC to dynamic, idol-busting, result-getting status it achieved under incumbency of Dr. Meiling.

New Cardiac Clinics

The Manchester Chapter of the Connecticut Heart Association has recently established a cardiac clinic at the Manchester Hospital. Announcement of the establishment of a clinic in New London was made by the New London Chapter. Funds for the purchase of necessary equipment have been offered by a citizen of New London and the chapter will assume responsibility for the operation of the clinic.

FROM OUR EXCHANGES

The Journal Lancet of October, 1951 (71.10) is a special issue devoted to cardiovascular disease. Various authorities have contributed major articles on many of its phases. The surgical treatment of constrictive pericarditis, major cardiac arrhythmias of apparent psychogenic origin in young adults, vena cava ligation in thromboembolic disease, massive thrombus of the left auricle (a case report) and the comparative susceptibility to endocarditis and glomerulonephritis in dogs with and without arteriovenous shunts are some of the matters discussed. It is a number of unusual interest to the physician who is alert to the surgical treatment of cardiac disease.

* * * *

Clark Tibbits *(North Carolina Med. Jour.,* 12.10) thinks that it is time that we gave attention to the growing problem of the conservation of our aging population. We are all of us getting older. Sooner or later, if we have the good fortune to live out our normal age span, we shall have a personal stake in this matter. The greatest fear that old people have is that of being set aside as useless, financially dependent, and unwanted.

Dr. Tibbits believes that the modern challenge is that of finding a solution to the problems of the aging. Aging men and women of today have made superior contributions and some still have much to give. The fruits of experience, skills and wisdom have come to them through the years and should not be lightly cast aside as useless and outdated. In Dr. Tibbit's opinion we have a need for what our older people have to give and he is convinced that the immediate task ahead is the conservation of our aging population.

* * * *

The Rt. Hon. Lord Horder in an address given at King's College Hospital Medical School *(Brit. Med. Jour.,* 4744) confesses that he has not been favorably impressed by the "new look" which the "practice of medicine in this country has recently worn." His chief reason for not liking it is that the doctor and patient meet "so seldom and for so short a time." He is of the opinion that the greater part of whatever virtue lies in medical care is resident in the personality of the doctor, and he seriously doubts that one can nationalize personality as can be done with gas, electricity and the railroads.

Dr. Horder does believe strongly in the State giving every facility to doctors for the proper carrying out their functions. He believes in regionalization (and in the rationalization) of hospital services. He believes in adding the dependents of the worker to the National Insurance Scheme. He believes in making the whole of medicine available to every citizen. But Dr. Horder's creed was to be "our Medicine, not Medicine as conceived by, and purveyed from, the bureau."

An interesting quote is taken from Karl Marx (which may come as a surprise to most doctors) that reads as follows: "For thousands of years Medicine has united the aims and aspirations of the best and noblest of mankind. To deprecate its treasures is to discount all human endeavor and human achievement as naught."

It has been written that the technology of medicine has outrun its sociology. Dr. Horder thinks that it will fall to the new generation of doctors to make the adjustment between the technology of medicine and sociology—and to make it without sacrificing the individuality of the patient who places himself in the physician's hands with such confidence and such hope.

* * * *

Ernest H. Watson *(G. P.,* IV.5) thinks that breast feeding is still a very good way to feed young infants. It is his considered opinion that 8 or 9 out of every 10 women, if the physician understands the psychology and physiology of breast feeding, can breast feed their babies. Use of the relief or liberty bottle will often remove the objections that some women raise and help in early weaning.

* * * *

"Doctors and the Federal Medical System—The Findings" is the title of a short article in *G. P.,* IV.5. The conditions of inefficiency and waste in the government's medical services as cited by Dr. Robert Collier Page are astonishing—and especially so to the medical profession. The construction of federal hospitals in the neighborhood of voluntary hospitals which have often been partially financed

by the government under the Hill-Burton Act, have seriously crippled the staff of these community hospitals. The lack of coordination between the Veterans Administration and the military authorities has resulted in duplication of facilities, in the building of hospitals, etc., while a nearby government hospital erected by another branch of government was being closed down, and in erecting hospitals in inconvenient locations, and in the building of costly hospitals ($50,000 per bed) that have remained empty from the time that they opened their front door. The government is doing an injury to the civilian population by stockpiling doctors in unnecessary institutions. Nonservice connected disabilities are treated for free to the tune of several hundred million dollars annually.

Dr. Page calls attention to the fact that the Federal Medical Services is a doctor's problem. Every action of the government in the area of medicine affects the private practitioner in one way or another. The federal government is the largest single employer of doctors and is the biggest operator of hospitals in the land. Government medical services have grown without overall supervision into a confused extravagant collection of competing agencies. They are wasting medical manpower and facilities and getting in each other's way. The maldistribution of doctors works out to the detriment of large areas of the population.

* * * *

Waterhouse-Friedrichsen syndrome has generally been described as the sequela to infection by the meningococcus. It was usually a fatal condition resulting from hemorrhages into the adrenal gland. The picture was one of sudden collapse, shock, high fever, a petechial rash and rapid downhill course.

Kahn and Butler *(Jour. Ind. State Med. Assoc.*, 44.11) remind us that the syndrome may occur as a complication or as part of the picture of a fulminating septicemia. Their own case occurred in connection with an infection with Hemophilus Influenzae, type B. Their report is well documented with laboratory data and postmortem findings.

* * * *

According to Witt and Titterington *(Missouri State Med. Assoc. Jour.*, 48.11) the pain in both acute and chronic subacromial bursitis is relieved by Roentgen therapy. This treatment is more effective in acute bursitis than in chronic disease. (Acute relieved in 96.2 per cent of cases treated. Chronic cases obtained relief in 85.8 per cent of cases treated.)

* * * *

Dermatoses which may become malignant, precancerous dermatoses, and cancerous dermatoses are discussed by Dennie and Fuhrman in the *Journal of the Kansas Medical Society*, 52.9, under the title "An Abstract on New Growths of the Skin and Their Management."

* * * *

In "The Diagnoses of Hyperthyroidism" by Solomon Silver *(N. Y. Med.*, 7.19) the author discusses basal metabolism, protein-bound blood iodine, and radioactive iodine studies, emphasizing in particular the use of the chemical determination of protein-bound iodine of plasma and the use of radioactive iodine. He believes these methods have greatly improved our ability to recognize hyperthyroidism, especially in cases where the clinical findings are not classic.

* * * *

"The Treatment of Hyperthryroidism with Radioiodine" by Yohalem *(N. Y. Med.*, 7.19) presents the experiences of a group of physicians at one hospital (Mt. Sinai, N. Y. C.) based on the observation of 830 patients with hyperthyroidism treated with I 131. This latter substance was supplied on allocation by the United States Atomic Energy Commission. Eight hundred and twenty-six patients were cured. The use of radioiodine is considered the treatment of choice in the majority of cases of hyperthyroidism.

* * * *

A thorough knowledge of the pathological physiology involved in cases developing jaundice results in a more rapid diagnosis than does the memorized knowledge of the hundred and one conditions which might be associated with this symptom, according to Thorek *(N. Car. Med. Jour.*, 12.9), Tracing the fate of a normal red blood corpuscle seems to be the proper approach to an understanding of icterus. The author's clinical classification divides jaundice into three types: prehepatic, intrahepatic, and posthepatic, thus identifying the lesion by its location. Also dividing the common duct into supra-, retro-, infra-, and intraduodenal sections aids in standardizing the various operative procedures applied to common duct surgery.

American Surgical

OFFERS YOU

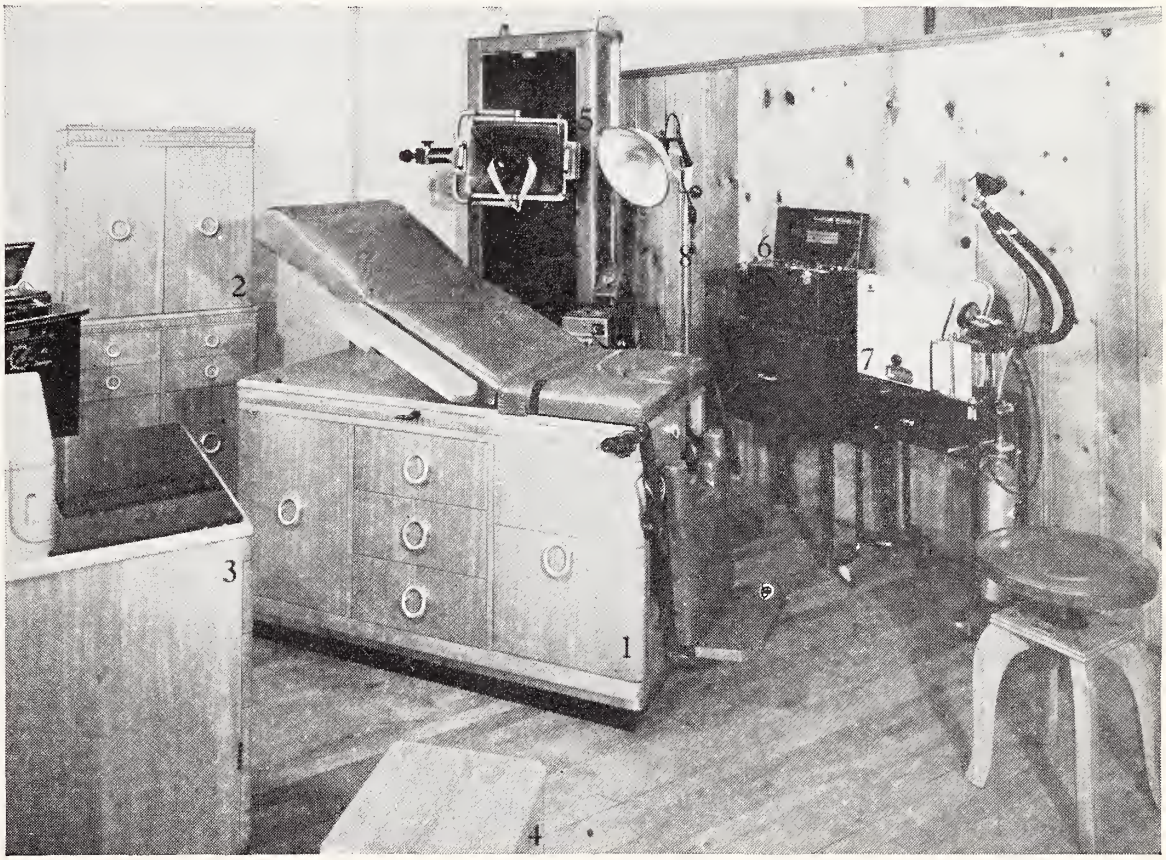
DISTINCTIVE

FURNITURE and EQUIPMENT

specially designed for beauty, practibility, and to save you valuable time and effort. Each unit is sturdily built by specialists with the finest materials available.

v is the "WINDSOR" Set in blond mahogany . . . the newest style in
. "Flowing" design best describes this entire suite; a note-
e of fine craftsmanship. The Table (1) has many unusual features,
e finger-tip control stirrups and the counter balanced back rest.
ded with sponge rubber, upholstered in Fabrilite in a choice
nd brown. The Instrument Cabinet (2) is of ample size; and
section is finished in white, equipped with three glass shelves,
llumination.

Stand (3)
lite work-
closed type
r drawers;
ompartments.
eptacle (4)
; has metal
; and foot
id.



ber (5) is the
ERICAN PHILIPS
ation Unit
Bell-o-
; the
scope
on-

. The Bell-o-scope can be attached to any fluoroscopic screen.
trocardiograph Unit as number (6) is designed for portability and
on. Pictured as number (7) is the McKESSON Waterless Basal
nd as number (8) is the CASTLE Office Light, designed for
heatless illumination.

ese incomparable pieces appropriately presented at our Show Rooms. The trained and
at American Surgical is ready to assist you in every phase of selection.

ican Surgical
SUPPLY AND EQUIPMENT COMPANY
AVENUE : P. O. BOX 150 : BRIDGEPORT, CONN. : TELEPHONES: 5-3116 or ENTERPRISE 3190

OBITUARIES



Alfred Collard Henderson, M.D.
1874 - 1951

Dr. Alfred Collard Henderson, retired pediatrician, died suddenly at his home in Stamford November 23, 1951. He was born in Brooklyn December 26, 1874.

Following his graduation from Amherst College in 1899, Dr. Henderson received his M.D. degree from the College of Physicians & Surgeons of Columbia University in 1903. He served as intern in the Gouverneur Hospital from 1904 to 1906. He then began practicing in New York City, spending a great deal of time working in the Babies Hospital where he became very proficient in the care of children.

In 1915, Dr. Henderson moved to Stamford and became the first pediatrician in that city. Soon his qualities of leadership became apparent. He was founder and director of the Pediatric Department of the Stamford Hospital and a member of the Hospital Medical Board. He was a member of the Connecticut State Medical Society, a past president of the Fairfield County Medical Association, and past president of the Stamford Medical Society.

In his quiet manner his guidance was felt in many community activities including The Red Cross, The Visiting Nurse Association, The Mental Hygiene Society, and the Presbyterian Church where he served as a member of its Board of Trustees.

Nationally, he was a Fellow of the American Medical Association, Fellow of the American Academy of Pediatrics, a Licentiate of the American Board of Pediatrics, a Fellow of the New York Academy of Medicine, and a member of the Medical Quiz Society. For years he served as assistant chief of clinic at the Babies Hospital in New York.

When all is added up, Dr. Henderson was quite a fellow: quiet, charitable, with a deep love for children and always ready to befriend his fellowman. All through his life there was evidence that an artistic talent was in concealment. When he retired in 1940, the artist element asserted itself. He purchased a violin and took lessons from an outstanding teacher in New York. His wife says it was surprising how short a time it took him to graduate from the "squeeky stage" to the production of real melody.

Surviving are his widow, Mrs. Ethel Pafford Henderson, two daughters, Dr. Jean Henderson and Miss Haideen Henderson, and a son, Charles McArthur Henderson.

Oliver L. Stringfield, M.D.

John J. Keating, M.D.
1909 - 1951

Dr. John J. Keating died October 8, 1951 at his home in New Milford, Connecticut. He was born in Danbury, Connecticut, on June 3, 1909. John Keating graduated from the Danbury High School in 1926; from Niagara University in 1930; and from New York University Medical College in 1934. He interned at Bellevue Hospital for two years, then opened his office for general practice in New Milford. In 1942 he entered the U. S. Navy and was discharged in 1946. At the time of his death he was a lieutenant commander in the U. S. Naval Reserves.

Dr. Keating was a member of the American Medical Association, the Connecticut State Medical Society, the Litchfield County Medical Association, and the Danbury Medical Society. He was on the staff of the New Milford Hospital and a member of the New Milford Lions Club.



Dr. Keating was an ardent hunter and fisherman—a valuable addition to the community and beloved by his patients and friends. He is survived by his wife and five children, Joan, Roger, Kevin, Colleen, and Alanna.

Howard G. Stevens, M.D.

THE DOCTOR'S OFFICE

Henry R. Corwin, M.D. announces the opening of his office for the practice of dermatology at 85 East Avenue, Norwalk.

Irwin T. Mancall, M.D. announces the opening of his office for the practice of ophthalmology at 750 Main Stret, Hartford.

Douglas D. Perry, M.D. announces the opening of his office for the practice of pediatrics at 279 Main Street, Bristol.

Robert J. Vernlund, M.D. announces the opening of his office for the practice of ophthalmology at 85 Jefferson Street, Hartford.

SPECIAL NOTICES

CONNECTICUT TRUDEAU SOCIETY

The Connecticut Trudeau Society, medical section of the Connecticut Tuberculosis Association, will hold its spring meeting at St. Francis Hospital, Hartford, Connecticut on May 15, 1952, at 8:00 P. M. The program offers a presentation and open discussion of four fifteen-minute papers as follows:

"Some Aspects of Mediastinal Tumors"
Leonard R. Kemler, M.D., Hartford

"Some Observations on Cardiac Surgery"
William H. Glenn, M.D., New Haven

"Studies of Delayed Hypersensitivity in Sarcoidosis"
George Frious, M.D., Newington

"Clinical Trials with Nicotinic Acid Derivatives: Preliminary Observations"
Kirby S. Howlett, Jr., Shelton

The Society extends a cordial invitation to interested physicians to attend this meeting at the Bishop McAuliffe Amphitheater.

MASSACHUSETTS ASSOCIATION OF MEDICAL TECHNOLOGISTS CHANGE MEETING DATE

The Fourth Annual Meeting of the Massachusetts Association of Medical Technologists, Inc., formerly announced for May 3 has been changed to May 24.

Place of meeting—Hotel Somerset, Boston.

Program will remain unchanged.

WORLD MEDICAL ASSOCIATION

The Sixth General Assembly of The World Medical Association will be held in Athens, Greece, October 12 to 16, 1952, and will be followed on October 17 by a meeting of the Medical Editors of the World.

AMA: CHICAGO: JUNE 9-13

More than 30,000 persons—15,000 physicians and 15,000 persons allied with the medical profession—are expetced for the annual AMA meeting in Chicago, June 9-13. Most of the activity will center at Navy Pier, not far from Chicago's Loop. The AMA Technical and Scientific exhibits will be located in this huge structure, which extends more than half a mile into Lake Michigan.

The Scientific Assembly will open with the General Scientific Meetings, Monday, June 9, at 9 A. M. These meetings will be held at Navy Pier, where the registration bureau also will be located. Registration will begin Sunday, June 8, at 10 A. M. At the Palmer House, the House of Delegates will meet for several days, as will various committees and councils.

In the Scientific Exhibit will be found special exhibits and question and answer conferences covering a wide variety of subjects.

AMA members are cordially invited to visit the AMA headquarters during the Chicago meeting. Visitors will be welcome any time from 8:30 A. M. to 4:00 P. M. Guides will be available for tours through the building.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1951-1952

MEMBERSHIP REPORT OF THE SECRETARY

FAIRFIELD COUNTY

Membership—January 1, 1951		666
New Members		48
Less:		
Deaths	7	
Resignations, transfers, non-payment dues, etc.	11	18
Net Gain		30
Membership—December 31, 1951		696

HARTFORD COUNTY

Membership—January 1, 1951		790
New Members		44
Less:		
Deaths	2	
Resignations, transfers, non-payment dues, etc.	12	14
Net Gain		30
Membership—December 31, 1951		820

LITCHFIELD COUNTY

Membership—January 1, 1951		112
New Members		8
Less:		
Deaths	2	
Resignations, transfers, non-payment dues, etc.	2	4
Net Gain		4
Membership—December 31, 1951		116

MIDDLESEX COUNTY

Membership—January 1, 1951		92
New Members		9
Less:		
Deaths	1	
Resignations, transfers, non-payment dues, etc.	4	5
Net Gain		4
Membership—December 31, 1951		96

NEW HAVEN COUNTY

Membership—January 1, 1951		735
New Members		61
Less:		
Deaths	7	
Resignations, transfers, non-payment dues, etc.	22	29
Net Gain		32
Membership—December 31, 1951		767

NEW LONDON COUNTY

Membership—January 1, 1951		148
New Members		12
Less:		
Deaths	3	
Resignations, transfers, non-payment dues, etc.	2	5
Net Gain		7
Membership—December 31, 1951		155

TOLLAND COUNTY

Membership—January 1, 1951		17
New Members		0
Less:		
Deaths	1	
Resignations, transfers, non-payment dues, etc.	0	1
Net Loss		1
Membership—December 31, 1951		16

WINDHAM COUNTY

Membership—January 1, 1951		61
New Members		4
Less:		
Deaths	0	
Resignations, transfers, non-payment dues, etc.	2	2
Net Gain		2
Membership—December 31, 1951		63

ASSOCIATE MEMBERS

January 1, 1951		11
New Members		0
Associate Members—December 31, 1951		11
Total Society Membership—January 1, 1951		2,621
New Members		186
Total Membership—December 31, 1951		2,807
Less:		
Deaths	23	
Resignations, transfers, etc.	55	78
Total Society Membership—December 31, 1951		2,729
Net Gain for year		108

TOTALS

Fairfield	696
Hartford	820
Litchfield	116

Middlesex	96
New Haven	767
New London	155
Tolland	16
Windham	63
	2,729
Associate Members	11
	2,740

REPORT OF THE EDITOR-IN-CHIEF OF THE CONNECTICUT STATE MEDICAL JOURNAL

Stanley B. Weld, *Editor-in-chief* — Frank Stafford Jones
Herbert Thoms, *Literary Editor* — Benjamin V. White

Harold S. Burr, *Associate Member*

The past year has seen little if any change in the format of The Journal. Each issue has continued to carry approximately 112 pages, occasionally more, and the ratio of reading matter to advertisements has been maintained at about 2:1. Published manuscripts written by members have far outnumbered those from nonmembers, there appearing an average of only one of the latter in each issue. This may be accounted for by the fact that The Journal is receiving a fewer number of papers delivered by guest speakers at meetings of the State Society.

There have been no changes made in any of the departments of The Journal. "Progress in Medicine" has continued to present resumés of recent work in every instance except one by a member of the Society. Dr. Thoms has been ably assisted in securing material for this section by Dr. B. V. White. "The Historian's Note Book" has been continued and from comments received is a worthy addition. The section formerly labelled "Medicine and the Veteran" now is captioned "Military Affairs," since the latter title seems better suited to the change in the physician's relationship to the armed services.

Much credit is due two of our members for faithfully carrying on the work of Dr. Paul P. Swett in the department known as "From Our Exchanges." The appreciation of the editors and of our many readers goes to Dr. Thomas H. Denne of West Hartford and Dr. Marshall C. Pease of Ridgefield for attempting and accomplishing this task.

The 1951 Convention Number contained the usual special features of the annual meeting: the complete program of the sessions, pictures of guest speakers, an historical article on "Medicine in Stratford in Its Early Days," illustrated by a few historical scenes of interest, and special advertising.

The cost to the Society of publishing The Journal has continued about the same for the past two years, i. e., slightly over $3 per member. An attempt was made to wipe out this deficit by engaging a local advertising representative but, as with each previous attempt of this kind, the results have not been encouraging.

The Editor-in-Chief had the privilege of arranging the program for a conference of state medical journal editors and business managers at the headquarters of the American Medical Association in November. Formerly the AMA had conducted an annual conference for secretaries and editors but this had been allowed to lapse. The Advisory Committee of the State Journal Advertising Bureau felt there was a need for such a conference for journal officers and, judging from comments received at the time and since, it filled that need quite satisfactorily. An editorial in the January 1952 issue of The Journal briefly commented on the two day session.

Each year shows evidence of added interest on the part of our readers in different sections of The Journal. It is the endeavor of your editors to keep the content at the level of the average physician in our State in order that the appeal may be as great as possible to the largest number. Your editors are constantly considering changes of greater or lesser degree in order to effect an improvement in the product. You must be aware that all concerned with publishing The Journal derive considerable pleasure from the task and experience a comparable amount of pride in the fact that our Journal maintains a place of leadership among the State Medical Journals.

Respectfully submitted,
Stanley B. Weld

REPORT OF THE COMMITTEE ON POSTGRADUATE EDUCATION

Hugh L. Dwyer, Jr., *Chairman*

Bliss B. Clark
James W. Colbert
Alan F. Delevett
Malcolm M. Ellison
Leslie E. Morrissett
Ashley W. Oughterson
Philip F. Parshley
A. Rocke Robertson
C. N. H. Long, *Associate Member*

The work of this Committee for the year 1951 was confined to the planning of the 1951 Clinical Congress which was held in New Haven on September 11, 12, and 13, 1951. The program for this Congress was arranged by a subcommittee under the direction of Dr. Paul Kunkel, of Newington. Dr. Eugene Cliffton, of New Haven, was responsible for the details of arrangement for the meeting. The Clinical Congress was apparently favorably received by those who attended, and the registration was somewhat greater than for the previous year. Much credit is due to Dr. Kunkel and Dr. Cliffton for the success of this meeting.

Work is about to begin on the 1952 Clinical Congress. It is planned to change the pattern of this meeting by holding the sessions entirely in the Yale School of Medicine and New Haven Unit of the Grace-New Haven Community Hospital. This will facilitate the parking problem, and it is the feeling of the Committee that papers given before smaller groups, allowing time for discussion will prove to be more satisfactory.

Respectfully submitted,
Hugh L. Dwyer, Jr.

REPORT OF COMMITTEE ON HONORARY MEMBERS AND DEGREES

Samuel C. Harvey, *Chairman*

Charles H. Sprague Thomas J. Danaher

The committee recommends that David Russell Lyman, M.D., Wallingford, be made an Honorary Member of the Society as an expression of the high respect and deep affection that its members have for him and that this honorary membership be bestowed upon Dr. Lyman by the President of the Society during the forthcoming fiftieth anniversary celebration of the founding of the Gaylord Farm Sanatorium.

It is particularly appropriate that the Society take this action since the organization of the Gaylord Farm Sanatorium and its incorporation in 1902 was accomplished under the aegis of the New Haven County Medical Association and efforts of the public.

More important, they selected exactly the right person to become its superintendent and physician, and he in 1903 at the ripe age of 27, was licensed to practice medicine in Connecticut. From that time to the present the institution has been Dave Lyman, and Dave Lyman an institution, where exemplary care and kindly sympathy for those in trouble, have produced an unique esprit de corps in its graduates, who return yearly to renew their acquaintance with him.

His reputation has brought him many honors, both locally and abroad. In 1916 he was given the honorary degree of Master of Arts at Yale and in 1942 the degree of Doctor of Science at Wesleyan. In 1943 he was awarded the high distinction of the Trudeau Medal. Even more important is the acclaim of his colleagues, as evidenced by his having been president of each of the leading societies concerned with tuberculosis: in 1918 of the National Tuberculosis Association, and in 1926 of both the American Clinical and Climatological Association, and the American Sanatorium Association. In Connecticut he has been president of the New Haven County Medical Association, and of the State Medical Society; he richly deserves the rare honor of being made an Honorary Member, by those who for some fifty years have known him intimately and well.

Respectfully submitted,
Samuel C. Harvey

REPORT OF THE COMMITTEE ON HOSPITALS

William M. Shepard, *Chairman*

Arthur J. Adams William H. Curley
Willard E. Buckley Joseph A. Fiorito
Maxwell O. Phelps

The chief concern of the Committee on Hospitals, during the past year has been the relation of Physicians and Hospitals. At the request of the Council, an auxiliary committee on Professional Practice in Hospitals was formed, and has been meeting with us. The Sections on Anesthesiology, Pathology and Radiology were asked to select two representatives each. The resulting sub committee is as follows:

Mario Garofalo Joseph O. Collins
Louis J. Hampton Christie E. McLeod
Michael D'Amico
Ralph T. Ogden

Prolonged group discussions, personal communications, resolutions and policy statements issued by the specialist groups, have all pointed to the conclusion that a number of hospitals in this State are now employing physicians under terms which permit the sale of their professional skill for a fee. The objections raised to this custom fall into the following categories:

1. On December 6, 1951 at Los Angeles, the AMA Board of Trustees recommended, and the House of Delegates reaffirmed that this is unethical.

2. Interposition of a corporation between a patient and a doctor may hurt the best interests of the patient.

3. Medical practice which comes under the control of lay bodies, corporations, or any third party, tends to attract a decreasing number of qualified physicians.

4. The end result of such corporate intervention is thus not only impairment of standards of treatment, but a shortage of qualified personnel.

5. The recent rapid growth of prepaid hospital and medical insurance, make this a critical time for the proper separation of medical from hospital functions.

If a physician is satisfied that his hospital relationship is ethically correct, on this score, we do not recommend interfering. If, however, there is doubt, or a certainty that his status is unsatisfactory, the first move to correct the situation should be started within the hospital staff organization. All members of the State Society should stand ready to assist a colleague in the details of such a correction, while not neglecting the administrative and financial problems involved for the hospital. Effective functioning of the hospital within its proper sphere, is certainly part of a physicians professional responsibility toward his patients.

If the best efforts of a physician and his staff colleagues should fail to achieve correction of an unethical situation, appeal to the appropriate committee of his County Association is in order. If no satisfactory arrangement can be reached through the County organization, the matter may then be taken to the State Committee on Professional Relations or the Council of the State Society.

The Judicial Council of the American Medical Association may, "at its discretion" consider a problem of this nature, but only after the three previously mentioned efforts have failed. One reason for this sequence is to allow the flexibility of arrangement necessary throughout the country, and even within our own State, due to varying local conditions.

On pages 35-38 of the January 1952 issue of the Connecticut State Medical Journal there is a copy of the pronouncement of the Board of Trustees of the AMA referred to previously. This should be studied by all interested parties, since it states the basis on which disagreements will be considered, should they ever reach the Judicial Council.

After considerable soul searching the AMA has come up with a reasonable and high minded statement of policy, which places first emphasis on the welfare of the patient, and responsibility for initiation of any corrective action on the physician. The committee recommends that this policy receive the support of our county and state organizations, and that disputes be accepted for arbitration when presented.

The Committee would like authority from the House of Delegates to present our case to the Connecticut Hospital Association and the Connecticut Hospital Service, backed by the unequivocal approval of this House. Anything less than general agreement would give weight to the argument that the doctors don't know what they want.

Respectfully submitted,
William Mac Shepard

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

Richard J. Hinchey, *Chairman*

Preston N. Barton
Harold A. Bergendahl
George H. Carter
Harold M. Clarke
Bernard S. Dignam
John N. Gallivan
Andrew J. Jackson
John F. Kilgus
Robert P. Knapp
Arthur B. Landry
Daniel F. Levy
Milton F. Little
J. Wister Meigs
Philip J. Moorad
Frank T. Oberg
Andrew W. Orlowski
Israel S. Otis
Crit Pharris
Arthur A. Tower
Paul W. Vestal
Vincent J. Vinci
Ellwood C. Weise
Harold W. Wellington
J. Alfred Wilson
C. Frederick Yeager

The following report of the Committee on Industrial Health of the Connecticut State Medical Society, covers the activities of this committee since the last yearly report made at the House of Delegates at the annual meeting in May 1951.

Twenty-seven members were assigned to the committee by the House of Delegates. This represented the dropping of three members and the replacing of two others, one of whom was Dr. Albert S. Gray who resigned because of his transfer from the Bureau of Industrial Hygiene to become the Deputy Commissioner of Health.

It is with deep regret that the Committee will not have the services of Dr. Gray as an active member. His advice, counseling and participation, particularly as an information center, was always a source of satisfaction and appreciation to the Committee as a whole and to the various chairmen in particular. However, he has frequently been invited, (and has accepted) to the several meetings of the Committee and its Executive group—as a consultant, and has assisted in the resolution of many problems confronting them. He was replaced by Dr. Kenneth Markuson, the new director of Dr. Gray's old department, who, unfortunately left the state service before he could atend a meeting. Dr. Markuson was not replaced.

Because of a brief agenda of non-pressing items the May meeting of the Committee was not held.

The first meeting of the Committee was held in the State Society building, in New Haven, October 24, 1951. Dr. John Kilgus was appointed secretary and eight members were elected to the Executive Board: Doctors Barton, Bergendahl, Carter, Clarke, Jackson, Pharris, Vestal, and Yeager.

Reports were discussed concerning post-graduate courses in industrial nursing at Yale University; of affiliation of health and safety activities under the same administrative head and the growing recognition of safety as a specialty; liaison between this Committee and the State Dental Association; legislative hearings on compulsory sickness indemnity insurance and workmen's compensation concerning free choice of physicians; requests for starting programs in industry to refer alcoholic cases to both out of state and in-state clinics; apparent attempts to by-pass existing plant medical facilities by interested professional and lay groups in their approach to industry through other plant departments on this problem; the request from the State Director of Civil Defense for the assistance of this Committee in studying medical aspects of Civil Defense problems in industry and assistance in recommending equitable stockpiling of supplies; and the inauguration of Health Services for State employees.

On November 5, 1951 at the State Society building in New Haven, the Executive Committee met with Dr. J. F. McCahan, the assistant secretary of the Council of Industrial Health of the American Medical Association, to discuss the past, present, and future activities of the Committee on Industrial Health of the Connecticut State Medical Society and how the functions of this Committee could be more accurately integrated with those functions of the American Medical Association Council on Industrial Health. Also discussed was the possible holding of a conference on some phase of industrial health on a state level and the American Medical Association's attitude on Civil Defense plans for industry. It was revealed, that at this time, while money was available in nebulous amounts at the federal, state, and local levels—industry would have to foot its own bills for stockpiling.

Another meeting of the Executive Committee was held at the State Society's office March 5, 1952, with Doctors Gray and Gallivan as guests.

Lengthy discussions took place concerning individual plant activities regarding stockpiling. No set pattern was revealed and while all industries discussed had increased their stockpiles it was not based upon any requirements that might be precipitated by any great disaster or upon the number of employees who might be injured. This was followed by a discussion of various plans on the medical aspects of Civil Defense in industry. Here again no set pattern was outlined, but all the plans considered were peculiar to the individual industry and its geography. This information was brought back to General Hesketh by Dr. Gray to assist the State office of Civil Defense in its future planning relative to industry's part in the over-all State plan.

Also discussed was the criticism of industry as a whole and certain plants in particular by some members of the State Society regarding the use of plant facilities by em-

ployees for non-occupational diagnosis and treatment, even at the written request or prescription of an outside physician. This objection and criticism was channelled to this committee through local and county associations. The Committee felt that it had reached the proper group for determining the use and abuse of these procedures and the chairman has appointed a sub-committee of Doctors Jackson, Gallivan, and Kilgus to study the over-all picture with the above complaints in mind and report to the committee as a whole regarding the ethics involved in consideration of present day accepted policies, with an attempt to set up standard procedures to guide industry in handling such problems in the future.

The last meeting of the present committee was to be held March 20, 1952, but due to conflicting meetings, at the County and State level, it had to be postponed, but will be held sometime before the annual meeting of the State Society.

It was hoped, that, coincident with this meeting, as had been suggested, a conference on some phase of industrial health on a state level could be held. This plan has been thought of carefully and preparations have been made to hold a symposium on, "Treatment of Industrial Back Injuries." However, due to the request of one of the sponsoring groups, the American Brass Company of Waterbury, Connecticut, it cannot be held until some time in June. Time, date, place, speakers and specific subjects will be forthcoming, and all those associated with industry and members of the State Society will be amply notified with the assistance of the Secretary's office.

Although no reports have been received from the county committees on industrial health since the last meeting with the county chairmen, it is felt that with their increasing responsibilities and the continued activity of the State Committee, the Connecticut State Medical Society will continue its high standing in leadership in all fields of industrial health as credited to them by the American Medical Association.

Respectfully submitted,
Richard J. Hinchey

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

CONNECTICUT MEDICAL EXAMINING BOARD FOR CALENDAR YEAR 1951

John D. Booth, *President*

Wilmot C. Townsend	Carl E. Johnson
Louis P. Hastings	John H. Bumstead

The State Committee on Medical Education and Licensure is also the Connecticut Medical Examining Board and the report of the Committee is essentially the official report of the Examining Board.

The operations of the Connecticut Medical Examining Board continue actively and this report covers those operations for the calendar year 1951. It may appear that 239 is a large number of physicians to be licensed in this state in a single year, but it should be borne in mind that included in this group were many hospital residents who were required to obtain licenses by the hospitals in which they were employed and when their period of training ended, they left Connecticut. It cannot be said how many of these 239 new licensees actually settled in practice or medical employment.

Physicians seeking to emigrate from Europe present an increasing problem to medical examining boards in the United States and Connecticut receives a large number of inquiries from them. The revision of the Medical Practice Act in 1941 provided a sound basis on which the Board could operate in relation to these problems of eligibility and the regulation adopted by the Board in April 1948 clarified the status of foreign graduates. It should be commented, incidentally, that the number of physicians seeking to leave England and come to America is steadily increasing.

The law which requires physicians serving as interns or residents in Connecticut hospitals to be eligible for licensure to practice medicine in the state, continues to cause confusion which is most often due to a lack of understanding on the part of the appointing authorities in the hospitals. The Board is at all times willing and careful to explain the operation of this law.

A total of two hundred and thirty-nine persons were certified as eligible for licensure, one hundred and nineteen presented certificates issued by the National Board of Medical Examiners, eighty-seven presented licenses issued by 23 states and thirty-three by virtue of written examinations. Of forty-five applicants who took the written examinations, thirty-three passed and twelve failed. Three of the failures were females, and nine males. Of seven osteopaths who took the examinations, seven failed medicine, one failed surgery and one passed surgery.

The Board held six regular meetings as required by statute and five special meetings. Charges against four Connecticut physicians were filed and heard by the Board during 1951.

With the discontinuing of teaching of homeopathic medicine at the Hahnemann Medical College of Philadelphia, graduates of this school subsequent to June 1951 will be licensed by the Connecticut Medical Examining Board and not the Connecticut Homeopathic Medical Examining Board. Graduates of five medical schools in Switzerland are now eligible for licensure if they present official certificates of medical studies in addition to the university degree in medicine.

The following schools outside of the United States were added to the list approved by the Board and graduates from them are eligible for licensure in Connecticut.

Belgium

Free University of Brussels Faculty of Medicine
Catholic University of Louvain Faculty of Medicine
University of Ghent Faculty of Medicine
University of Liege Faculty of Medicine

Canada

University of Ottawa.

A statistical analysis of the candidates certified by the Board follows:

NUMBER OF LICENSES ISSUED BY INDIVIDUAL STATES

New York	36	California	1
Maryland	8	District of Columbia	1
Pennsylvania	7	Georgia	1
Massachusetts	5	Louisiana	1
Michigan	4	Maine	1
Illinois	3	Minnesota	1
Virginia	3	Mississippi	1
Kentucky	2	Missouri	1
New Jersey	2	North Carolina	1
Ohio	2	Tennessee	1
Vermont	2	Texas	1
West Virginia	2		

WRITTEN EXAMINATIONS, MARCH-JULY-NOVEMBER 1951

School	*Passed*	*Failed*	*Total*
Chicago Medical	1		1
Columbia	1		1
Creighton		1	1
Jefferson	2		2
Long Island	1		1
Loyola	2		2
Maryland	1		1
New York Medical	1		1
Pennsylvania	1		1
Vermont	5	1	6
Yale	1		1
FOREIGN SCHOOLS			
Basel (Switzerland)	1		1
Berlin (Germany)	1		1
Berne (Switzerland)	2		2
Bologna (Italy)		2	2
Budapest (Hungary)	1		1
Charles (Prague)	1		1
Copenhagen (Netherlands)	1		1
Dublin (Ireland)	1		1
Frankfort (Germany)		1	1
Havana (Cuba)	1	1	2
Lausanne (Switzerland)	1		1
Naples (Italy)	1	1	2
National University (Ireland)	1		1
Paris (France)	1		1
Queens (Canada)	3		3
Toronto (Canada)	1		1
Vienna (Austria)		5	5
Total	33	12	45

Respectfully submitted,
Creighton Barker,
Secretary to the Board

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

John W. Buckley, *Chairman*

Clement F. Batelli
Henry Bunting
Alfred L. Burgdorf
Clair B. Crampton
George Gura
Gilbert R. Hubert
Robert R. Keeney, Jr.
Luther K. Musselman
J. Harold Root
H. Peter Schwarz
R. Bruce Thayer, Jr.
Alfred J. Trimpert
William A. Wilson
John A. Woodworth
F. Lee Mickle, *Associate Member*

The Committee on Public Health held meetings during June, July, September, October, November, and December, 1951; and during January and March, 1952, with an average attendance of nine members. Three members were unable to attend any meeting.

Guests who were invited to contribute clarifying information as an aid to discussion have included: Doctors Martha Clifford, Hester Curtis, and James Hart of the State Health Department; and Dr. Norton Canfield.

In fulfilling its official function as "representative of the Connecticut State Medical Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare," the Committee on Public Health has studied a large number of diverse topics related to its purpose.

Because of the very nature of its interests, the committee was in frequent consultation with the State Health Department. Appointments of additional physicians to the Obstetrical and Pediatric Consultation Services were made by the Health Department after approval by the committee. Also, appointments of physicians to preside at the State Health Department's well child conferences were similarly effected.

Formerly, certification by the American Board of Obstetrics and Gynecology or the Board of Pediatrics was an absolute requirement for consultants in cities with a population of more than 50,000. At one meeting of the committee, a change in the qualifications of consultants was recommended. The unanimous approval of the committee was given to the following two revisions in the Handbook on Consultation Service for Obstetric and Pediatric Patients:

Page 7, item 1: "A member of the staff of the local hospital for at least three years; and either certified by the American Board of Obstetrics and Gynecology or having the equivalent training and experience required by the Board."

Page 17, item 1: "A member of the staff of the local hospital for at least three years; and either certified by the American Board of Pediatrics or having the equivalent training and experience required by the Board."

The committee also participated in a revision by the State Health Department of its standard procedures for physicians attending its well child conferences.

After an extended period of study, the Subcommittee on Hearing and Speech prepared a set of recommendations, which were approved by the committee. The recommendations are:

1. That the Committee on Public Health first endorse an economic survey of the problems of hearing and speech in the State of Connecticut;

2. That the Committee endorse acceptable programs in the State working on the problems of hearing and speech;

3. That the Committee refer questions on Industrial Noise Trauma to the Sub-Committee on Noise in Industry of the Committee on the Conservation of Hearing, of the American Academy of Ophthalmology and Otolaryngology,

Howard House, M.D., 1136 West 6th Street, Los Angeles 17, California, Chairman.

4. That the Committee designate this committee as the Sub-Committee on Hearing and Speech.

The Committee on Public Health is currently engaged in an appraisal of the medical and social problems inherent in illegitimacy and in the adoption of children. It has arranged a joint meeting of the Committee on Public Health with a statewide committee covering welfare, hospital, health, social service, family service, juvenile courts, adoption agencies, and the Connecticut State Farm for Women.

The Subcommittee on Still-Births and Neonatal Mortality, working with the Maternal and Child Health Bureau of the State Health Department, is arranging to provide in-service training for nurses in the premature nurseries of some of the State's larger hospitals. In a similar coöperative venture, this Subcommittee and the Bureau have also devised forms to simplify the study of their infant mortality experience by hospitals.

One of the subcommittees of the Committee on Public Health is the Crippled Children Technical Medical Advisory Committee, of which Dr. Edward T. Wakeman is chairman. During 1951, this group has achieved the following outstanding contributions:

1. The completion and publication of *The Study of Cerebral Palsy in Connecticut*, which will be sent to all physicians in the State.

2. A cerebral palsy demonstration clinic for physicians and therapists, held at Newington in November, 1951.

At several meetings during the year, many aspects of school health problems were discussed. Impressed by the frequency and the complexity of questions regarding school health, the Committee on Public Health has considered the advisability of sponsoring a statewide conference on school health in coöperation with the State Departments of Health and Education.

It has been a pleasure to sense the initiative and the support of the active members of this committee. The unfailing coöperation of the physicians of the Connecticut State Health Department and of the executive personnel of the Connecticut State Medical Society has also been deeply appreciated.

Respectfully submitted,
John W. Buckley

REPORT OF THE CRIPPLED CHILDREN TECHNICAL MEDICAL ADVISORY COMMITTEE

Edward T. Wakeman, *Chairman*

Norton Canfield	Edward J. Ottenheimer
Burr H. Curtis	Robert P. Rogers
David Gaberman	Robert Salinger
Denis S. O'Connor	William M. Shephard

C. Norton Warner, Jr.

The Crippled Children Technical Medical Advisory Committee, a subcommittee of the Committee on Public Health, did not hold any formal meeting in 1951 due to the temporary leave of absence of Louis Spekter, M.D., chief of the Division of Crippled Children. The chairman was in touch with E. B. Sinclair, M.D., acting chief, and with Dr. Spekter when necessary.

One outstanding accomplishment of the crippled children program in 1951 was the completion and publication of *The Study of Cerebral Palsy in Connecticut*, copies of which will be sent to all physicians in the State. It should be noted that answers to the study questionnaire were received from seventy-six per cent of Connecticut physicians.

In November 1951, Dr. Meyer Perlstein, pediatrician and specialist in cerebral palsy from Chicago, conducted a cerebral palsy demonstration clinic for physicians and therapists at the Newington Home and Hospital for Crippled Children. This demonstration was very well attended and enthusiastically received. More clinics of similar nature should prove popular as a medium of post-graduate education.

In 1950 the Technical Medical Advisory Committee advised that scholarships for training in cerebral palsy be made available to physicians, physical therapists and occupational therapists. It was recommended that the orthopedic surgeons in particular who are consultants to the Division of Crippled Children be urged to have additional training in cerebral palsy. Scholarships were accepted in 1950 by Dr. Alexander Bassin and in 1951 by Dr. Russell Fuldner, Consultants to the Division of Crippled Children who completed two weeks courses in cerebral palsy in Chicago, Illinois.

The New Haven Rheumatic Fever and Cardiac Program, sponsored by the State Department of Health, New Haven Department of Health and the Department of Pediatrics of Yale University School of Medicine, is part of the service of the state crippled children services. It offers diagnostic and treatment services to physicians and their pediatric patients who have heart disease, especially congenital heart disease, or are suspected of having heart disease. It is interesting to note here that the following operations (with a very low mortality rate) on congenital heart cases were performed during the past four years and three months in New Haven. Many of these children were referred to the state crippled children services: Patent ductus arteriosis—68; tetralogy of Fallot—56; coarctation of the aorta—23; exploratory thoracotomy—13; vascular ring—3; transposition of the great vessels—3; omphalocele—extra pericardial—1.

The New Haven Rheumatic Fever and Cardiac Program also provides annually a Workshop on the Public Health Aspects of Rheumatic Fever and Pediatric Cardiology as well as training Fellows in Pediatric Cardiology.

In the 1950 report of this committee it was recommended that ways and means be considered to bring about a closer relationship between local physicians and the Division of Crippled Children clinics. Some of the activities of the Crippled Children program already in effect which tend to bring physicians closer to the program are:

1. Integration of services of the local cardiac clinics in Putnam and Willimantic with the crippled children services so that physicians may see children as well as adults at the local clinics.

2. Participation of local pediatricians in the crippled children clinics held in Willimantic and in Norwich. They can learn something of orthopedic conditions in children.

3. Participation in the Torrington crippled children clinic by a local practicing orthopedist has been effected. He attends the clinic with Dr. Pike.

4. The referral form has been modified to allow physicians to request consultation alone, or consultation and treatment. In this way it was felt the clinics might have some teaching value and allow the referring physicians to carry on treatment. After each clinic visit the referring physician receives a copy of the clinic notes. This too may have some educational value.

In addition, it is planned to have demonstration clinics to bring information to local physicians so that they can treat with confidence more of the minor orthopedic problems themselves. This will help to reduce the case load of minor conditions now in clinics.

Respectfully submitted,
Edward T. Wakeman

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, *Chairman*

David H. Bates	Gaert S. Gudernatch
Harold A. Bergendahl	Morris A. Hankin
Burdette J. Buck	Harry C. Knight
John E. Flaherty	Frank C. McMahon

Planning of the Committee on Public Relations has been concentrated on community service programs, coöperation with allied groups and information techniques.

This represents a return to long-range programs set aside for a number of months to coöperate with the American Medical Association's National Education Campaign. The campaign continues to be active, though not on such an extensive scale as previously.

Five meetings of the committee were held during the year. The first step to advance community services comprised a study started last May of the programs sponsored or planned by associations in other states. This study resulted in publication of *Main Street Frontier*, a guide for development of community service programs by county medical associations.

The program contains seven points, establishment of emergency medical call systems, formation of committees to adjust patients' complaints, guarantee of physician services for everyone, advancement of voluntary health insurance, support of the American Medical Association's Education Campaign, improvement of relations with press, radio and community groups, and information programs for association members.

The principle of community service has been endorsed by county medical associations and progress in developing local programs is encouraging. Emergency medical call systems are now operating in nine of Connecticut's principal communities and in several others are scheduled for early activation. In a number of smaller communities the service is being adapted to local needs. Other phases of the program also are attracting increasing support and action.

Release of information through newspapers and radio continued throughout the year. Special services in this connection included preparation of a weekly column, *Your Health*, for the 55 weekly newspapers in the state, a survey and account of new hospital construction and the furnishing of useful information to newspaper editorialists.

Two leaflets concerning activities of county, state and national medical associations were published, one for distribution to physicians, the other for distribution to the public through physicians' offices, and organization meetings and mailings.

Assistance also was furnished in writing and publishing a booklet for the Public Relations Committee of the Woman's Auxiliary. The booklet accents the value of information concerning the activities and accomplishments of medical associations and is to serve as a guide in public relations activities for Auxiliary members.

A new service was initiated to channel current information of public relations activities and socio-economic developments to county association officers and committee members. A section on these activities also was written for each issue of the Connecticut State Medical Journal, in addition to a special page devoted to leading aspects of the program.

Information concerning medical association activities was furnished to the *Journal of the American Medical Association*, the *Connecticut Pharmacist*, and a number of organization newsletters.

Another informational service comprised the use of exhibits at county fairs in cooperation with the Society's Committee on Rural Health and the Committee on *Today's Health* of the Woman's Auxiliary. Appropriate exhibits also were used at medical meetings and an exhibit is now being planned for display at the June 18-20 meeting of the New England Health Institute at the University of Connecticut.

Considerable time was devoted to cooperating with other groups. These activities included making arrangements for speakers at organization meetings, assisting in conference planning and furnishing information for service clubs and other organizations.

The desirability of having a public relations committee in each county to study and coördinate local programs became evident early in the planning stage. Committees have now been appointed by the Medical Associations of Hartford, New Haven, Fairfield, Middlesex and Litchfield Counties and they are demonstrating their value in developing programs suited to the needs of their associations.

Last October our committee was requested by the Council of the Society to plan and conduct a Connecticut campaign for the American Medical Education Foundation. A plan was developed at the next committee meeting and the first campaign material was mailed December 10. Further details of the campaign are presented in another report.

Your committee desires to express appreciation for the coöperation of the large number of physicians who have made possible the progress of community service programs.

These services are winning valuable good will by demonstrating in terms easily understood by everyone that the profession can meet the needs of the people right in their own communities.

Respectfully submitted,
William G. H. Dobbs

REPORT OF THE CANCER COORDINATING COMMITTEE

Allan J. Ryan, *Chairman*

Alfred L. Burgdorf	William Mendelsohn
Matthew H. Griswold	Edward J. Ottenheimer
Louis P. Hastings	Benjamin R. Reiter
Ralph E. Kendall	Francis A. Sutherland

There were 6 regular meetings of the committee which were well attended. The business contracted during the year included the following:

1. Appointment of a Medical Advisory Committee to the Connecticut Cancer Society.
2. Projects directed toward professional education.
3. Implementation of the Cancer Detection Program.
4. Miscellaneous.

1. MEDICAL ADVISORY COMMITTEE

Drs. A. Burgdorf and G. Carter resigned and their resignations were accepted. The vacancies were filled by Drs. T. Evans and M. Taffel. The other members of the committee remaining are Drs. D. Wells, E. Ottenheimer and R. Glazier.

2. PROFESSIONAL EDUCATION

This committee has coöperated with the Association of Tumor Clinics to arrange for the Fourth Annual State Cancer Conference to be held in New Haven in March. The program has been ably administered under the direction of Dr. E. Cliffton of the Yale Medical School, Dept. of Oncology.

The film "Gastro-Intestinal Cancer—Easy Diagnosis" was reviewed by this committee and received a favorable response. The film was purchased by the Connecticut Cancer Society and the Connecticut State Department of Health.

The Committee has continued to subsidize various types of Cancer literature which are being mailed to the doctors in Connecticut. Dr. Griswold has been especially helpful in this project.

3. CANCER DETECTION

This project represents the culmination of almost two years of continued effort by this committee. A list of doctors has been prepared and will soon be announced to the public by suitable publicity. The Connecticut Cancer Society will supervise the distribution of the lists and it is expected that each County Medical Society will eventually assume the responsibility for this project.

It must be emphasized that the list of doctors who have expressed their desire to participate in the program is incomplete. Many cards were returned too late for inclusion in the present list. Because of unavoidable inaccuracies which may have been incurred in the preparation, it is hoped that our doctors will help in editing this list by writing to the Cancer Coördinating Committee.

4. MISCELLANEOUS

The committee began exploratory talks with the Connecticut Hospital Association in order to arrive at some decision regarding the responsibility for the operation of Tumor Clinics in the various hospitals.

A prize was sponsored for the best paper on a subject dealing with cancer. This will be under the auspices of the Connecticut Association of Tumor Clinics.

Initial action was taken for a program to improve the education of nurses regarding cancer.

Respectfully submitted,
William Mendelsohn

REPORT OF THE COMMITTEE ON PROFESSIONAL RELATIONS

James A. Gettings, *Chairman*

George H. Carter	Clifford D. Moore
Harold W. Higgins	Ralph T. Ogden
Elliot H. Metcalf	Frank L. Polito

Chester Waterman

The Committee on Professional Relations has had but two cases brought to their attention; one from New London County and one from Fairfield County, and in neither case was it necessary to call together the entire committee for action. The executive secretary is conversant with the facts of both of these cases.

Respectfully submitted,
James A. Gettings

REPORT OF THE COMMITTEE ON MENTAL HEALTH

Franklin S. DuBois, *Chairman*

Harold L. Amoss	Daniel P. Griffin
John H. Bumstead	Foster E. Priddy
Charles W. Culotta	Solam Segel

G. Gardiner Russell

At the time of its last report, this Committee was actively engaged in the support of legislation designed to establish a central administration of the mental health program in the State. Unfortunately, the bills (HB1497; SB689—identical measures) did not gain the approval of the 1951 General Assembly. However, the Committee believes that the State Society should continue to support the principle of central administration for the sake of efficiency, economy and improved care of the mentally ill, and lead a state-wide educational program to give the public knowledge and to gain popular demand for such a measure at the next session

of the legislature. Specifically, the Committee recommends that the President of the State Society or the Council appoint a small committee to carry on such a program of education and publicity during the next two years.

A second project of the Committee has been that of determining both the facilities and the needs for psychiatric care and teaching in the State. In obtaining information relevant to these problems, a questionnaire was sent to each of the 34 general hospitals in Connecticut (Appendix A). Details dealing with outpatient psychiatric services will be discussed in a subsequent report of the Committee, but a summary of this phase of the problem together with a compilation of data reference inpatient services and teaching are recorded in Appendix B. Critical study of this Appendix reveals that only seven hospitals offer inpatient psychiatric care. Of these, four are in Hartford (Hartford Hospital, St. Francis Hospital, John J. McCook Memorial Hospital, Mt. Sinai Hospital), one is in New Haven (Institute of Human Relations), one in Waterbury (Waterbury Hospital) and one in Greenwich (Greenwich Hospital). In addition, St. Raphael's Hospital in New Haven indicated that a few patients were accepted for electroshock treatment and the Meriden Hospital in Meriden reported that it occasionally served a psychiatric patient for a brief period. Hence, it is apparent that facilities for the treatment of the mentally ill are by no means as generally available as are those for the treatment of the physically ill. In fact, it would seem that opportunities for adequate inpatient care of the mentally ill are grossly inadequate in the State at large. Aside from a few urban centers, the entire patient load is passed on to the state hospital system or to private sanitaria for intramural management.

Because of this fact, it naturally follows that teaching programs in psychiatry for residents and interns are few (18 per cent of the hospitals) and opportunities for physicians and psychiatrists to share problems are but slightly more frequent (Appendix B—3,6,7). Only 16 hosiptals have attending psychiatrists while 8 others have consulting psychiatrists. Thus, 10 hospitals offer no psychiatry whatsoever. Nurses fare better than doctors inasmuch as 41 per cent of the hospitals provide training in psychiatric nursing, largely through affiliation with the State hospitals (Appendix B—5). These facts lead to the inevitable conclusion that the teaching and practice of psychiatry in the general hospitals of Connecticut is far behind the teaching and practice of other branches of medicine, a condition that should be corrected.

Until recent years the only places available for the care of the mentally ill were the many State and the few private institutions. Most of the public mental hospitals, including those in Connecticut, are now crowded, exceeding their normal capacity by 20 to 35 per cent. Furthermore, the incidence of mental illness is increasing. The population of mental hospitals has grown over 100 per cent in the past 50 years, due not only to greater total population of the country, but also to increased life expectancy. Thus today approximately one-third of the patients in such hospitals are over 65 years of age. For these reasons the medical profession and general hospitals have an ever increasing responsibility to attack mental illness in its early stages with modern methods of treatment. By and large the general hospitals of Connecticut are not meeting their obligation to care for the ill of the community, inasmuch as a very large segment of those sick are mentally and not physically ill. In fact, it is said that emotional disorders account for at least 25 per cent of all admissions to general hospitals. More and more communities and more and more hospitals throughout the United States are recognizing the urgent need for psychiatric pavillions. The first such unit was established in Albany in 1902. In 1940, 89 general hospitals provided such facilities. In 1945 there were over 100, while in 1951 there are 279 hospitals with psychiatric wards treating several hundred thousand patients annually.

The advantages to the hospital of such a partnership are obvious. The psychiatric service cares for short term psychoses such as medical and surgical patients with delirium, drug psychoses, etc., and psychiatric consultations are available for the handling and treatment of lesser emotional disturbances. By combined ward rounds the staff physician and surgeon may learn something of psychiatric problems and the psychiatrist something of medical and surgical problems, a rapport which is becoming imperative.

Psychiatric units in general hospitals relieve the state institutions of many diagnostic admissions and short term psychoses which can be quickly and effectively treated. In addition, because of superstitution, social stigma, and distance from home, patients and their families often will agree to admission to a general hospital but not to a mental institution, until the situation becomes so severe or so complicated that care at home is impossible. Thus the patient who can be treated promptly in his own community is saved time, money and untold suffering.

Early recognition and modern treatment of emotional problems are expanding the psychiatric field tremendously. The age-old chasm between mental illness and physical illness is being, and rightly should be, narrowed, until mergence is complete. An important and, in fact, an imperative step in this direction is the addition of psychiatric facilities to every general hospital of any size.

It is this Committee's considered opinion that for both medical and economic reasons every such hospital in Connecticut should have a psychiatric service the same as it has medical, surgical and obstetrical services. Only in such a setting can adequate, comprehensive and genuinely effective medicine be practiced. The Committee believes that the State Medical Society should take a position of leadership in sponsoring a program designed to bring an inpatient psychiatric service to every general hospital in Connecticut.

Respectfully submitted,
Franklin S. DuBois

Appendix A

Questionnaire Sent to Each of the 34 General Hospitals of Connecticut

1. Does your hospital have an out patient psychiatric service? If not, please so state; if so, please give us patient load, general activities of the clinic and other information that you may consider pertinent.

2. Does your hospital have an in patient psychatric service (ward and/or private accommodations)? If not, please so state; if so, please describe in detail the size, patient load, and activities of this service.

3. Does your hospital have a teaching program in psychiatry for interns, residents and/or nurses? If not, please so state; if so, please describe such teaching facilities in detail.

4. Does your hospital have available personnel in psychiatry (interns, residents, attending or consultants)? If not, please so state; if so, please designate number in each category. How active are these members of your staff?

5. Does your hospital have affiliations with psychiatric hospitals? If not, please so state; if so, please outline the extent of these affiliations, what they comprise and how they function.

6. Does your hospital have facilities available for attending physicians to participate in psychiatric problems (bedside teaching, ward rounds, conferences, and/or lectures)? Are these facilities used by the attending physicians and, if so, to what extent?

7. Does your hospital have facilities available for attending psychiatrists to participate in medical problems (bedside teaching, ward rounds, conferences and/or lectures)? Are these facilities used by the attending psychiatrists and to what extent?

Appendix B

The Teaching and Practice of Psychiatry in the 34 General Hospitals of Connecticut

Question No. 1. No. of hospitals with outpatient psychiatric services 11

Question No. 2. No. of hospitals with inpatient psychiatric services 7

Question No. 3. No. of hospitals with teaching programs in psychiatry for interns, residents and/or nurses..... 10
(4 of which have only for nurses)

Question No. 4. No. of hospitals with available personnel in psychiatry (interns, residents, attending or consultants 24
(8 of which have only consultants)

Question No. 5. No. of hospitals that have affiliation with psychiatric hospitals 14
(all for nurses, training periods at state hospitals)

Question No. 6. No. of hospitals with facilities for attending physicians to participate in psychiatric problems 12

Question No. 7. No. hospitals with facilities for attending psychiatrists to participate in medical problems..... 16

REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

Walter I. Russell, *Chairman*

Howard S. Colwell — N. William Wawro
Daniel Hardenbergh — Benjamin V. White

This committee meets with representatives of the Yale School of Medicine consisting of the following; Dean C. N. H. Long, George B. Darling, William T. Salter, James W. Colbert, A. W. Snoke and Hugh L. Dwyer.

An item of major importance is resident staff training, as it is now being seriously jeopardized by CMS and other private insurance coverage. Most of these patients are now removed from ward service. A special study is being made by conferences with groups interested in the problem of ward service care and resident training, as the ward patient in the surgical and obstetrical specialties is fast vanishing.

Consideration of better coöperation of Yale Alumni in Medicine with the School of Medicine, and a closer liaison between these two bodies, has been taken up. Much improvement in this respect during the past five years, is conceded.

Regional medical schools have been discussed. Acceptance of these students means that the State from which they came will pay the cost of their education.

A Governor's Commission in this state is now concerned with the thought of starting a new medical school in Connecticut. The concensus of this committee appears to be that there is no great pressure from the profession, at present, for a new school.

In the event of the formation of a new medical school, Dean Long and the faculty of the Yale School of Medicine will be glad to give any advisory help possible.

Increased facilities for training students by the use of the Veterans Administration Hospital in West Haven and the new Grace-New Haven Community Hospital, both under construction, have been talked over.

It appears that the Veterans Administration is experiencing some intramural difficulties over differences of opinion as to professional education within its bounds. The interrelationship of medical school and Veterans Administration Hospitals is now under analysis by members of Congress.

Many subjects have been discussed at our meetings; The various Congressional bills for financial aid to Medical schools; The Intern matching plan as it is now carried out; The medical R.O.T.C. program; Desire on the part of the Medical School to further the State Medical Society in the furtherance of post graduate courses for physicians, and various others.

The committee is giving intensive study to the resident training program and if and how semiprivate and private patients may be available to this program.

Respectfully submitted,
Walter I. Russell

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Harry C. Knight, *Chairman*

J. Grady Booe — Winfield O. Kelley
Barnett P. Freedman — Hyman A. Levin
Ralph L. Gilman — Edward R. Smith
E. Myles Standish

Since the active and efficiently organized Woman's Auxiliary of the State Medical Society functions so smoothly and with such splendid understanding of its relationship to the problems of the State Medical Society, there has been little work for this committee to do. One meeting of

the committee was held in conjunction with the annual school of instruction of the Auxiliary, at which time approval was given to the acceptance of the sum of $300 from the CMS for the privilege of including in the bulletin informational material of interest to the members of the Auxiliary. Several other minor questions were discussed and approved. It was agreed that there were many aspects of the Public Relations program of the State Medical Society which should be emphasized by the Women's Auxiliary and a talk was given to the school of instruction on this subject by the chairman of this committee. The chairman has attended the annual and semi-annual meetings of the Auxiliary and has maintained frequent advisory contact with the President of the Auxiliary, although nothing of importance arose for action by the committee.

Respectfully submitted,
Harry C. Knight

REPORT OF THE AMEF CAMPAIGN IN CONNECTICUT

Brae Rafferty, *Chairman*
William G. H. Dobbs, *Administrative Chairman*

Edwin R. Connors	David G. Rousseau
James R. Cullen	Walter I. Russell
Albert M. DeTora	Samuel Spinner
Thomas M. Feeney	Oliver L. Stringfield
Louis E. Garston	R. Bruce Thayer, Jr.
Ralph Gilman	Harold W. Wellington
John F. Kilgus	John A. Woodworth
Christie E. McLeod	Edgar C. Yerbury

The Society's Council initiated action last October to conduct a fund-raising campaign in Connecticut for the American Medical Education Foundation.

Responsibility for planning and conducting the campaign was accepted by the Committee on Public Relations, in coöperation with a state-wide committee of medical association presidents and secretaries.

The first campaign appeal to members of the Society was mailed December 13 and the response has been encouraging. As of March 19, contributions and pledges totalled $6,026 by 136 physicians. In addition, 59 physicians indicated they are contributing directly to their medical schools. Cash transmitted to the American Medical Education Foundation as of the above date totalled $4,936.

Responses by counties, including those who indicate direct payments to medical schools, were as follows: Hartford County—59; New Haven County—49; Fairfield County—36; New London County—14; Litchfield County—13; Middlesex County—12; Windham County—9; and Tolland County—3.

The purpose of the Foundation is to provide an instrument through which physicians may make contributions to aid the 79 approved medical schools in the United States. Contributions may be earmarked for any one of these schools or for the AMEF general fund. Administrative costs are underwritten by the American Medical Association and the State Medical Society so that every dollar contributed reaches the Foundation or the medical school for which it is designated. Contributions have been ruled deductible for income tax purposes.

The Foundation is a non-profit corporation and its activities are being implemented by the National Fund for Medical Education, organized to raise funds from non-medical sources and headed by former President Herbert Hoover.

During 1951, the first year of AMEF existence, $745,917 was contributed by 1,811 physicians, 33 organizations and 33 lay friends of the profession. The rapid progress of the campaign this year, with most State Medical Societies actively enrolled in the program, promises a substantial gain over the 1951 achievement.

Your committee appreciates the early generous response of Connecticut physicians to this important national effort. Additional opportunities will be extended to participate in the 1952 campaign and those who have not yet contributed are invited to do so.

Respectfully submitted,
Brae Rafferty

REPORT OF THE JOINT CONFERENCE COMMITTEE OF THE CONNECTICUT STATE MEDICAL SOCIETY AND CONNECTICUT PHARMACEUTICAL ASSOCIATION

Barnett Greenhouse, *Chairman*

Benjamin Katzin	Allan K. Poole
Walter J. Keefe	Louis Soreff
Fritz M. Meyer	William F. Wener

This Committee continues to serve as an essential link between the State Medical Society and the State Pharmaceutical Association. The Committee has met four times in the past year according to schedule. The meetings are well attended and its deliberations are friendly and of serious import, helping to maintain understanding and friendly relations between the two societies.

No major problems have confronted the Committee during the past year, except that it became involved in a report issued by the State Food and Drug Commission in reference to the prescribing and dispensing of barbiturates. The report in some of its aspects was challenged at a meeting of this Committee, and the matter gained considerable press and editorial notice.

The barbiturate question has constantly been on the Committee's agenda in an effort to resolve it through continued education. The Council of the State Medical Society subsequently appointed a special committee of its own to investigate the problem even further.

The Committee on Foods Drugs Cosmetics and Devices, which is an autonomous subcommittee of this Joint Conference Committee, is each year increasing in value and prestige. Its scientific deliberations are sought and respected, serving a long felt need for evaluation of products distributed in this state for professional and public use. Professor Nicholas W. Fenny is chairman of this subcom-

mittee and Dr. Harry J. Fisher its perennial and essential secretary.

Respectfully submitted,
Barnett Greenhouse

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

D. Olan Meeker, *Chairman*

Creighton Barker	Clifford D. Moore
William H. McMahon	Charles T. Schechtman
Henry Merriman	Edward P. White

"The purpose of this Committee is to be informed constantly concerning proposed national legislation relating to medical care and welfare. The Committee shall advise the Council on details of proposed legislation in the fields of health and welfare and express its opinion, with appropriate approval, to Connecticut representatives and senators in the Congress of the United States. The Committee shall endeavor to keep members of the State Medical Society informed on trends and developments in national legislation that may be expected to affect medical service."

Fortunately, as far as being "informed constantly" is concerned, this is capably cared for by reports from two organizations. One is the American Medical Association Washington Office, of which Dr. Joseph S. Lawrence is the director, and Dr. Frank E. Wilson deputy director, and Dr. Cyrus H. Maxwell, assistant director. This highly efficient organization issues three types of reports, one called "Capitol Clinic." another "Bulletin" of the particular Congress in session, and third, "Special Bulletins" which give dossiers of various members of Congress and committees dealing with medical legislation. They also issue Special Bulletins from time to time dealing with one particular subject.

The other organization is the Committee on Legislation of the American Medical Association, with headquarters in Chicago under the secretaryship of C. Joseph Stetler. This committee issues a report called "Legislative Review," which lists the various bills in Congress, by whom they are introduced, to what committee they are referred, the subject, and the interested AMA council or department.

As a result of the intensive work on the part of these two committees, the mass of information which is received is enormous. It is practically impossible to keep track of the devious ways and means by which our socialistic-trending government attempts to insinuate itself into medical life involving both the profession and the laity. In reviewing these reports it would seem that one has as much chance of stopping the advancement of this type of legislation as of stopping water running from a strawberry barrel using only two hands. Fortunately, a great many of these bills die aborning and consequently it is only to bills which attack the fundamental philosophy of medical practice in America that our efforts need be directed.

As an example, in August, September and October, 1951, there were exactly 50 bills introduced which were considered to come within the scope of interest of the American Medical Association. These included a bill to investigate the efficiency of cancer treatment, a study of problems of the aged, establishing a presumption of service connection for Veterans with poliomyelitis who were P.O.W., expanding health services for chronic diseases, expansion of out-patient health services, scholarships for nursing education, establishing a bureau of accident prevention, a study of air pollution, a study of multiple sclerosis, a classification of drugs, an advisory committee for the blind, deduction of medical expenses for income tax purposes, social security for dentists, a federal agency for physically handicapped, the national leprosy act, and, finally, federal aid to health insurance plans. As a result of this overwhelming information and our isolation from Washington, it seemed to the Committee as if we were dealing with a hundred-armed octopus. It was only occasionally that we could come up for air and conclude that it might be necessary to wire, or talk to a senator, or go to Washington.

There were actually three occasions this past year when definite action was considered imperative. One concerned the Ecton amendment to HR4473 which would permit deduction of medical expenses, including health and accident insurance premiums, from income, for tax purposes. Dr. Lawrence, the head of the Washington Bureau of the AMA, wired Dr. Barker on September 25 to that effect. Dr. Barker in turned wired Senators Benton and McMahon on September 27, stating that the physicians of Connecticut urged thorough consideration of this amendment. It was felt that since the present law exempts these items only in excess of 5 per cent that passage of this amendment would stimulate sales of voluntary health insurance. Unfortunately, the Ecton amendment was rejected.

The second occasion was on October 15, at which time Dr. Barker wired Senators Benton and McMahon stating that the physicians of Connecticut urged inclusion in the tax bill of permission for taxpayers over 65 to deduct medical expenses.

The third occasion was a visit to Washington on May 28 to meet the various members of the Washington Bureau. I was conducted through the entire organization and had a firsthand glimpse of how they work. I must say that it is efficiently organized and that personal contact with senators and congressmen on the hill is maintained constantly. It is possible for the Washington Bureau to predict highly accurately exactly how each senator and congressman will vote and by knowing this to occasionally steer legisation at the proper time for its rejection or passage.

At the time of that visit your chairman had the opportunity to speak personally to Senator McMahon for a period of about thirty minutes regarding the Government's attitude on the education of medical students. It was our hope that some legislation might be introduced similar to the Hill-Burton Bill for the building of hospitals, which would allow, by some means, money for the education of medical students and the enlargement of medical schools without any actual supervision or dependency upon the Federal Government. It was rather amusing to hear that one particular Senator that day was considerably disturbed because he had been unable by personal contact to have two of his

sons admitted to medical school. Your chairman told Senator McMahon that that was just the type of thing that must be avoided at all costs. Had this Senator been a member of a Federal Committee dealing with medical education he might have in all possibility pulled out a few stops, and maybe a few deans of medical schools, to get his sons in.

One bill in which we had considerable interest was the amendment of Senator Ives of New York to the House-passed tax bill HR4473. This amendment would, under certain circumstances, exempt from taxation limited premium payments for retirement plans of professional and other specified associations—provided such plans had prior approval of the United States Treasury Department. Senator Ives explained that such an exemption would correct an unfair situation. He pointed out that it was designed to bring relief to highly educated persons who are not covered by Social Security and who had, after prolonged schooling and training, fewer earning years than the average person now covered by Social Security. Physicians, he explained, reached their peak from 10 to 19 years after commencing practice. Increased rates of taxation take dollars from professional persons at a time when they should be setting aside funds for retirement years.

The Ives proposal would permit eligible persons to pay each year—tax free—to an approved organization's retirement plan 10 per cent of earned income, or $7,500, whichever is less. Professional, business, and other associations would submit their retirement plans to the United States Treasury Department for approval. To be approved such plans would provide that premiums could not be withdrawn voluntarily before retirement (60). The insured, however, could draw benefits before age 60 for total and permanent disability. Upon retirement, the insured, or his beneficiaries, could elect to take a lump sum payment or accept annual installments. Under the lump sum payment agreement, the total amount would be subject to a Capital Gains Tax not exceeding 25 per cent (present rate). Under yearly instalment the insured or his beneficiaries would be subject to regular income tax payments.

On September 18, 1951, the Senate Finance Committee reported the Revenue Bill but did not include the Ives amendment. The Committee had been notified by Senator Ives that he would not introduce his amendment on the floor since insufficient studies had been made of the plan and the vote on the measure would be premature and possibly prejudicial to its eventual passage. Several members of the Finance Committee have agreed to study the proposal more thoroughly next year.

Your chairman talked with Dr. Cyrus H. Maxwell, Assistant Director of the Washington Office of the AMA on January 23, 1952. As yet the Finance Committee has not met to reconsider the bill for this session. We are to be advised when this bill will come up for consideration in sufficient time to send in letters in its favor.

It is the recommendation of this Committee that the Ives amendment be discussed in the individual medical societies throughout the state and that a vote be taken on its acceptance or rejection. If, whenever the Ives amendment is presented, the Connecticut State Medical Society is able to send to our senators and congressmen a statement that every medical society in the state has voted favorably for the passage of this amendment, it would do a great deal toward influencing our legislators toward affirmative action. It is only by a concerted action of this type that we can hope to secure favorable results. Individual telegrams and communications are good but they bear little weight in the eyes of a politician who is looking toward the desires of the mass of constitutents.

A report was received from the AMA Washington Office on November 21, 1951, as to the status of medical legislation at the close of the first session of the 82nd Congress. This contained the status of medical legislation only. There were 179 bills and resolutions introduced during that session. It is gratifying to report that at least some of the legislation which the AMA approved was enacted into law and none of the bills which were actively opposed were enacted.

Opposition by the Council of the AMA to a great many of the bills was on the basis that the Federal Government is insinuating itself into purely local and state situations. We have found recurring again and again the attempt to lift problems from the level of local consideration into the national field. This basic philosophy of insinuation into local situations is echoed by the President in his message on the State of the Union on January 9, 1952, at which time he said: "We urgently need to train more doctors and other health personnel, through aid to medical education. We also urgently need to expand the basic health services in our own home communities—especially in defense areas. The Congress should go ahead with these two measures immediately.

"I have set up an impartial commission to make a thorough study of the nation's health needs. One of the things this commission is looking into is how to bring the cost of modern medical care within the reach of all our people. I have repeatedly recommended national health insurance as the best way to do this. So far as I know, it is still the best way. If there are any better answers, I hope this commission will find them. There is one thing I am sure; something must be done—and be done soon."

I think this succinct remark on the part of our President is sufficient to remind us to be on our toes as regards the continued attempt of the Federal Government to socialize medicine in particular.

Respectfully submitted,
D. Olan Meeker

REPORT OF THE COMMITTEE ON STATE BLOOD BANK

Ralph E. Kendall, *Chairman*

Irving B. Akerson
Gerald J. Carroll
Joseph O. Collins
Daniel H. Deyoe
Frederick Hartman
Louis P. Hastings
Lincoln Opper
Karl T. Phillips
J. Geoffrey Snavely
Vincent J. Vinci
Levin Waters
Donald B. Wells

As the Connecticut Regional Blood Program approaches the end of the second year of operation, your committee wishes to extend to the staffs and volunteer workers of the forty-one chapters of the American Red Cross in Connecticut, its congratulations for the enviable record they have established.

Although the Connecticut Program is the thirty-first center established by the Red Cross, it is at present among the first half dozen in the volume of blood procured of the forty-four in operation. It ranks third in blood collected for civilian hospital use and is unique in that it provides blood for all the hospitals throughout the state. In the last annual report it was noted that the monthly collection had reached the figure of 7,500 pints. The corresponding figure this year is 12,500 pints, an increase of sixty-six per cent. Over a third of this is for the Army and Navy, nevertheless more than 70,000 pints will be provided for the patients in the hospitals of the state.

There are now in operation four mobile units with a daily quota of 150 pints each. During the year, the fourth unit was added in order to extend the collection for the Army and Navy to the State of Rhode Island. There is no civilian program in operation or planned for Rhode Island. In addition to the mobile units there is a permanent bleeding center in Hartford which might well be duplicated in the other larger cities. About one-third of the hospitals continue to act as bleeding centers in close cooperation with their local Red Cross chapter, thereby supplementing the over-all program, providing a training center for bleeding techniques and serving as a stand-by unit in case of emergency.

Few of us are aware of the intricate organization and projected planning that is necessary in order to maintain the constant daily flow of over 500 pints of blood. Donor recruitment remains the number one problem and requires the active cooperation of every physician with the efforts of their local Red Cross Chapter. The second problem, the judicious use of blood so provided, is entirely the responsibility of the doctors. Blood transfusions have progressed to the point where their administration is a comparative safe procedure, nevertheless, dangers still exist and with each transfusion the hazards must be balanced with the needs. We must particularly avoid the "tonic," the "cosmetic" transfusion or the transfusion given "to satisfy the family that something is being done."

In the leading hospitals throughout the country, eight to nine pints of blood per year are required per active hospital bed. This is also true in many of the hospitals in this state. When the usage, as it is in some hospitals, is double this figure it would seem that some of these transfusions were probably not necessary. This problem of the use of transfusions must, we feel, receive the earnest attention of all of us. It would be regrettable if our thoughtlessness led to a quota or planned system of such a valuable therapy.

Respectfully submitted,
Ralph E. Kendall

REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, *Chairman*

Egbert M. Andrews	Norton Canfield
George A. Buckhout	Joseph N. D'Esopo

Four meetings of the committee were held during the year. Routine business included contract negotiations, review of fee schedules and correction of minor operational problems.

Eleven grievance cases were heard by the committee. Nine of these were presented by the Veterans Administration and concerned incorrect filing of reports by participating physicians. Two physicians appeared before the committee to present cases in which they disagreed with the findings and practices of the Administration. Satisfactory adjustments were arrived at in all cases.

Several meetings were attended by officials of the Veterans Administration who have been most coöperative in helping to meet problems as they arise. This relationship frequently has made it possible to forsee problems and initiate corrective action before they assume large proportions.

The committee has reviewed the proceedings of a conference concerning veterans medical care programs held by the American Medical Association last June in Atlantic City. Resolutions by several organizations opposing acceptance of non-service connected cases by VA hospitals also have been reviewed. The problems involved are so comprehensive that very thorough study is necessary to prepare for any purposeful discussion of these matters. It is therefore noteworthy that the American Medical Association's House of Delegates at its mid-winter meeting last December appointed a committee to conduct such a study. Our committee has been notified that this study will include the following aspects of veterans medical care: (1) medical and hospital benefits for veterans with nonservice-connected disabilities; (2) medical and hospital benefits for dependents of service personnel; and (3) transfer of seriously disabled service personnel from service hospitals to Veterans Administration installations.

More than 1,300 physicians are participating in the Veterans Home-Town Medical Care Program in Connecticut. This is to say that approximately 75 per cent of the Society's members whose type of practice is needed in the program are now enrolled. Based on our state veteran population of approximately 275,000, it can be said there is a fee-basis physician available for every group of somewhat more than 200 veterans. It is believed this percentage of physician participation is among the highest in the country and effectively demonstrates the interest of the profession in caring for our veterans.

Our committee is deeply appreciative of the efforts of every participating physician in this important program and stands ready to assist in problems that may arise.

Respectfully submitted,
Samuel B. Rentsch

REPORT OF THE REPRESENTATIVES TO THE CONNECTICUT HEALTH LEAGUE

Luther K. Musselman, *Chairman*

John W. Buckley — Edward J. Whalen

Our Society was represented at the formation of the Connecticut Health League which occurred on May 15, 1950. In addition, some of our members have served as officers and directors of the League since the constitution and by-laws were adopted on November 14, 1950.

To date, the main purpose has been to correlate to some degree all phases of medical care including dentistry and public health programs and their objectives. At present, it would appear that the main function of the Connecticut Health League will be of an educational and coöperative nature. As time passes, I am of the opinion that its interests and activities will be extended. The Health League merits the support of our medical profession as well as any agency which is concerned with the health of our citizens.

Respectfully submitted,
Luther K. Musselman

REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, *Chairman*

Edward H. Basden — Enos J. O'Connell
Gaert S. Gudernatch — William H. Pomeroy
William H. Upson

The Rural Health Committee again this year displayed exhibits in the small Country Fairs of the State. Because of the active coöperation of Mrs. Willard E. Buckley, Chairman of the *Today's Health* Committee for the Woman's Auxiliary the exhibits were better manned than ever before. The Committee is indeed grateful to Mrs. Buckley for her splendid help. The exhibit was changed somewhat over the previous year but the slogan, "Better Health Is Your Job Too," was continued. There seems to be a very definite interest in this type of exhibition and the Committee intends to continue this work. We strongly urge that any doctor from the Medical Society who happens to be in the vicinity of one of these small Fairs and notices the exhibit of this Society should tarry awhile in order that those who see the exhibit may know that we are interested in promoting better health education amongst Rural People.

The Committee was represented on the planning for the coming New England Health Institute, which is to be held at the University of Connecticut on June 18, 19, and 20. In this connection we served on the Sub Committee of Community Planning and Study. This Institute will apparently be an important affair and the Committee was happy to be allowed a chance to aid in the development of the program.

This year the State Society had two representatives at the National Conference on Rural Health held in Denver in March. These conferences continue to increase in stature and in attendance.

During the year the Committee has given talks to three rural groups on health and it is to be hoped that more groups will avail themselves of the opportunity to have one of the members discuss with them better health in rural areas.

Respectfully submitted,
Norman H. Gardner

REPORT OF THE COMMITTEE ON THE CARE OF THE CHRONICALLY ILL

George A. Wulp, *Chairman*

Richard I. Barstow — James S. Missett
Sidney Drobnes — Michael S. Shea
Alexander J. Tutles

Facilities for the care of the chronically ill, as well as for rehabilitation, in Connecticut are continuously expanding. The State Commission has been granted the old Grace Hospital property in New Haven which has forty beds. In addition there will be one hundred and ten more beds available there later this year when the present patients are moved to their new building. There is a full time trained physician rehabilitation therapist now in charge of the New Haven group, and he is expanding both the inpatient and outpatient care. The construction of the additional unit at the New Britain Memorial Hospital should be completed fairly soon and this will add sixty-five beds there. At Bristol, additional personnel and equipment have been obtained to enlarge their facilities for rehabilitation. The facilities at Rocky Hill are the hub of the Connecticut plan and it is suggested again that phyisicians not acquainted with the work being done there, avail themselves of the opportunity to visit that hospital. At the present time, Stamford, Bridgeport and Bristol also have available facilities for the care of the chronically ill and to at lesser extent, for rehabilitation.

At the last meeting of your committee, it was felt that the most practical way to bring to the attention of the physicians in Connecticut the progress being made in the care of the chronically ill and rehabilitation might be by means of case reports to appear periodically in the Connecticut State Medical Journal. Material is being accumulated and it is hoped that we may be able to inaugurate this feature in the near future.

Respectfully submitted,
George F. Wulp

REPORT OF THE COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Carl E. Johnson, *Chairman*

Eric H. Blank — Charles H. Peckham
Joseph H. Howard — W. Leslie Smith
Norman C. Margolius — Hoyt C. Taylor
Hugh K. Miller — Stanley B. Weld
Jessie E. Parkinson — Elizabeth C. Wells

This Committee held seven meetings during the year. The total number of deaths for the year in which maternal

causes might be considered was 17; of these deaths only 8 were found to be due to pregnancy.

The modus operandi of this Committee was demonstrated in two open meetings during the year. The first was held in the Yale School of Medicine, for the third year students, and the second meeting was held in the Hartford Hospital.

In 1949 there were eight deaths definitely assigned to hemorrhage; in 1950 there were three; while in the year 1951 only one death was directly attributable to hemorrhage. The Committee feels that this is quite significant since hemorrhage was formerly the greatest single cause of maternal deaths. Connecticut can be proud, justly, that it has a blood bank in every hospital that has obstetrical service.

The maternal mortality rates for Connecticut for the past five years are as follows:

1947	1948	1949	1950	1951
0.7	0.6	0.6	0.5	0.1

Six states, namely Massachusetts, Texas, Minnesota, Oklahoma, Michigan and Wisconsin, have requested information regarding our maternal mortality program.

In spite of the exceptionally low mortality rate for 1951 the Committee feels that the State will continue to improve its obstetrical record.

Material on cases studied during the five years prior to 1951 has been assembled for analysis, and will soon be ready for publication.

Respectfully submitted,
Carl E. Johnson

REPORT OF THE COMMITTEE ON STUDENT MEMBERS

Morris P. Pitock, *Chairman*

Ralph D. Alley — Allan K. Poole
James D. McGaughey — Arthur C. Unsworth
Robert P. Noble — John B. Wells
Creighton Barker

Activities of the Society's Committee on Student Membership have lain dormant for many years. With the formation of the Student American Medical Association, your committee has become aware of the need to encourage the Students of Yale Medical School to active participation in this organization. Accordingly, a meeting of the committee was arranged in July, to which Mr. James Luce, a senior Medical Student was invited. Your committee wished to learn something of the attitude of the student body towards the new national organization. It was felt that Mr. Luce could give reliable information on the subject, having been active in the executive council at Yale Medical School, and an interested participant in efforts to start a chapter of SAMA at Yale. It was his opinion that organization of a chapter of SAMA at Yale Medical School would be difficult, that such an organization would desire to be free of the influence of both the Connecticut State Medical Society and the AMA. He thought that the interest of the students might be aroused over problems concerned with 1. Choice of Interns; 2. Housing, 3. Discrimination; 4. Government Health; 5. Information on political attitudes of Organized Medicine. He felt that the impetus for the formation of a chapter of SAMA at Yale must come from within the student body. No activities could be undertaken until the Fall, after the school opened.

During the current school year, several efforts have been made to stimulate interest of the student body, both in student membership in the Connecticut State Medical Society and in the formation of a chapter of SAMA. A proposal to invite Junior and Senior Medical Students to the December 20 meeting of the House of Delegates fell through because Christmas holidays began on December 18. A letter to C. N. H. Long, M.D.; Dean of Yale Medical School, suggested that some encouragement to students by the school authorities might stimulate the formation of a chapter of SAMA at Yale Medical School. Dean Long's reply stated "I would be less than frank if I did not tell you that it was reported to me that there is almost complete student apathy in this school towards the Student American Medical Association."

Your committee has been advised to delay further activity until September 1952. It is hoped that during the next college year, a more sympathetic attitude towards SAMA will be evidenced by the school authorities.

Respectfully submitted,
Morris P. Pitock

REPORT OF THE SOCIETY'S REPRESENTATIVES ON THE BOARD OF DIRECTORS OF CONNECTICUT HOSPITAL SERVICE, INC.

Creighton Barker — Thomas J. Danaher
Edward H. Truex, Jr.

The year just passed has been one of utmost importance to Connecticut Blue Cross. Toward the end of 1950, it became apparent that changes would have to be made in the hospital service contract. The premium charged at that time was not adequate to meet the expense involved and with the increasing cost of hospitalization, the per diem allowance of $6 against board and room did not meet a substantial part of the cost. A new contract was devised which increased the per diem allowance from $6 to $9 and additional premium charged to meet this cost and the increasing charges that were being made for special services.

This contract became effective on April 1, 1951. During the first few months of 1951, there were many cancellations because of the increased rates and the Service continued to operate at a deficit. Finally, however, the losing trend was halted and with diligent efforts on the part of the sales division, additional subscribers were enrolled to take the place of those cancelled out, so that at the end of 1951, there was a net loss of only 10,454 subscribers. Actually, 219,243 cancelled, but there was a gain of 208,789 in new enrollment. As of December 31, 1951, the total enrollment was 997,133, which is 80,000 more than in 1949, but 10,000 less than in 1950. Similar financial results were shown and the reserve for contingencies was sharply de-

pleted, but with the reversal of the trend, the reserve has again been built up to a satisfactory level.

In 1951 151,476 subscribers were hospitalized at a cost of $13,688,108.63 as compared with 142,253 cases in 1950 and a cost of $10,613,025.98. In the fifteen years of Blue Cross in Connecticut it has paid over 60 million dollars for 871,438 cases, 22,335 Blue Cross babies were born in 1951 and a total of 129,791 since 1937.

Changes have been made in the operation of the Corporation. Harry B. Kennedy, who has been the President of the Corporation, since it has been organized in 1937, was named President-Emeritus at the annual meeting on March 11, 1952, and he was succeeded as President by Solomon Elsner of Hartford, who had been Vice-President for a number of years. The Executive Secretary of this Society continues as the Secretary of the Corporation. Other physician directors are William H. Curley, Jr., Thomas J. Danaher, Edward H. Truex, Jr., and Paul W. Vestal. Last fall, Mr. Parnall, who had been serving in the dual capacity of General Manager of Connecticut Hospital Service and Connecticut Medical Service, withdrew from the latter assignment, he is no longer officially connected with the administration of Connecticut Medical Service, and was succeeded as General Manager by William H. Horton, a member of this Society.

Respectfully submitted,
Creighton Barker

REPORT OF THE COMMITTEE ON EXPERT MEDICAL TESTIMONY

Louis H. Cohen, *Chairman*
John S. Nolan Thacher Worthen

This Committee has made an inquiry into the difficulties which doctors who appear as expert witnesses in court encounter in their relationships with lawyers. Some twenty-three prominent attorneys and physicians, considered representative of both professions, were interviewed and their opinions of one another's attitudes and conduct were sifted and evaluated. Their recommendations for an improvement of the various specific difficulties were also requested. The major objections as reported by the physicians were that court work is largely a waste of time, that remuneration is inadequate and fees difficult to collect from attorneys, that there is a fear of the stigma of being considered a "court-room doctor," that there is resentment against use of the subpoena, and that the humilations of cross-examination are hard to endure. The point of view of the lawyers, on the other hand, consisted mainly of unfavorable criticism of the doctors' failure to understand or appreciate legal procedure, particularly with respect to the nature of opinion evidence, the use of medical jargon, the failure to testify according to the doctrine of reasonable probability, his tendency to consider cross-examination as a personal attack, and his failure to appreciate that his function is that of a witness and not of an advocate, his lack of knowledge of the proper limits of medical testimony and privileged communication, and his tendency to slant his facts or opinions in order to be "helpful" to the case. Various general recommendations for removing or ameliorating these various difficulties have been made, mainly in the form of the appointment of a non-partisan panel of experts, the fixing of fees, and of a plan for mutual education in medico-legal problems.

The Committee recommends that steps be taken for it to be joined to a similar committee of the Connecticut State Bar Association, if one were to be formed, in order to continue its studies and eventually to make concrete recommendations which may result in the adoption of some practical procedures for the improvement of expert medical testimony.

Respectfully submitted,
Louis H. Cohen

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE STATE DEPARTMENT OF EDUCATION

Orville F. Rogers, *Chairman*

Elisabeth C. Adams	Benjamin Wiesel
Ralph L. Gilman	Charles C. Wilson

The above named Committee has had two meetings and, together with representatives of the Teachers' Colleges, has discussed at length improvement in the physical examinations for admission and has further considered the necessity for intelligent utilization of the data gathered in the admission examination to the advantage of both the school and the student. The following recommendations have been proposed but have not been finally adopted at the date of this report:

1. The number of approved medical examiners should be increased. It is suggested that a rough guide to the number should be one examiner to approximately 30 approved candidates.

2. The State or County Medical Societies should recommend the examiners to the Commissioner of Education for appointment. It is hoped that a body of able medical examiners may be developed who will take a real interest in the medical selection of candidates for the important profession of teaching.

3. One or more part time medical advisers should be appointed for each Teachers' College. Without adequate follow-up the pre-admission physical examination loses much of its value. The medical adviser should conduct follow-up and health conferences with students, advise the staff on participation by the student in physical education and athletics, and on health matters which relate to the student's studies. The medical adviser should establish cooperative relations with the family physician wherever necessary and possible.

4. Each of the Teachers' Colleges should have a medical Advisory Committee. The membership should consist of a group of examiners, the medical adviser, representatives of the administration and faculty of the college, and representatives of some of the specialties, such as ophthalmology, otolaryngology, and psychiatry. The composition of the

committees might vary between the colleges to some degree, depending on the availability in the vicinity of all of the components mentioned.

5. The fee for a physical examination by an approved examiner should be $5.

6. It is also recommended that an annual chest film be required of each student.

Respectfully submitted,
Orville F. Rogers

Seward and Monde

Certified Public Accountants

205 Church Street
New Haven 10, Connecticut

The Connecticut State Medical Society
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1951 and the related statements of income and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence by methods and to the extent we deemed appropriate.

General Fund:

Cash in banks, which was reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

Commercial accounts:		
Phoenix State Bank and Trust Company	$1,529.85	
The Capitol National Bank and Trust Company—Journal revolving fund	3,600.00	
The Second National Bank and Trust Company—Executive secretary revolving fund	3,000.00	
The Second National Bank, Trust Department	6,495.46	
		$14,625.31
Savings accounts:		
The New Haven Savings Bank	$ 5,671.45	
Connecticut Savings Bank of New Haven	12,671.46	
National Savings Bank of New Haven	10,162.62	
Chelsea Savings Bank of Norwich	10,273.81	
		38,779.34
		$53,404.65
Petty cash—Journal office		5.00
Total		$53,409.65

On February 26, 1952 we examined at the Second National Bank of New Haven the following investments:

Stock:	BOOK VALUE	MARKET VALUE
45 shares Diamond Alkali 4.40% cum. conv. preferred stock	$4,500.00	$4,803.75

United States Treasury Bonds:

RATE AND MATURITY		
2 %, 1953	2,500.00	2,496.88
2½%, 1969	2,500.00	2,420.31
2½%, 1970	5,000.00	4,821.88
2½%, 1971	2,500.00	2,409.38
Total	$17,000.00	$16,952.20

Dues receivable of $3,220 are segregated by counties as follows:

COUNTY	AMOUNT
Fairfield	$ 670
Middlesex	50
Litchfield	25
New London	75
Hartford	1,950
New Haven	375
Tolland	50
Windham	25
Total	$ 3,220

Accounts receivable—Journal of $530.99 consist of 1951 advertising accounts which were paid in 1952.

Accounts payable—Journal of $20.83 represents amounts due for printing expenses.

The following is a comparison of budgeted and actual general expenses:

	BUDGET	ACTUAL	ACTUAL OVER OR (UNDER) BUDGET
Secretary's office	$29,775.32	$28,351.36	($1,423.96)
Treasurer's office	2,180.00	2,101.74	(78.26)
General and contingent	4,550.00	5,303.04	753.04
Public relations	8,860.00	8,715.32	(144.68)
Committee allotments	2,400.00	1,358.62	(1,041.38)
Building maintenance	6,250.00	6,623.26	373.26
Journal	31,250.00	32,666.39	1,416.39
Total	$85,265.32	$85,119.73	($ 145.59)

Annual Meeting Fund:

Cash of $10,076.35 in the New Milford Savings Bank and a balance of $3,155.99 in The Union and New Haven Trust Company was confirmed directly.

Gurdon W. Russell Fund:

Cash of $3,480.14 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

We examined the following securities held by this fund at the Second National Bank of New Haven:

PAR VALUE	VALUE DECEMBER 31, 1951 PER BOOKS	MARKET
$691.12 New York, New Haven and Hartford Railroad Co. 4%—due 2007	$ 458.00	$ 466.50
$985.61 New York, New Haven and Hartford Railroad Co. 4½%—due 2022	338.00	570.42
$523.27 New York, New Haven and Hartford Railroad Co. 5%—Series A	134.00	243.32

$1,000.00 Boston and Albany Railroad Company, 4¼% improvement bonds, due August 1, 1978	820.00	790.00
$5,000.00 U. S. Treasury bonds, 2¼%—due 1959	5,000.00	4,962.50
Totals	$6,750.00	$7,032.74

O. C. Smith Fund:

We confirmed the principal and income cash of $1,302.04 in the Mechanics Savings Bank, Hartford, by direct correspondence.

Building Fund:

Cash on deposit at the Second National Bank of New Haven in the amount of $748.52 was confirmed directly. During the year funds have been transferred from the general funds to the reserve for depreciation. The cash so transferred was confirmed directly with the depository.

Clinical Congress:

Cash of $3,311.01 in the New Haven Savings Bank and a balance of $119.13 on deposit at The Second National Bank of New Haven was confirmed directly by the depositories.

The Secretary's office has acted as collection agent for The American Medical Association's dues and The American Medical Education Foundation for the year 1951. At December 31, 1951 there was on deposit $162.50 and $2,505 on hand representing collections during the month of December not remitted to The American Medical Association. These amounts do not appear on the attached statements. It was noted that the Society's fidelity bond does not cover the Society's employees for the handling of these funds nor does The American Medical Association bond such employees.

In our opinion, the accompanying balance sheet and statements of income and surplus present fairly the position of The Connecticut State Medical Society at December 31, 1951, and the results of its operations for the year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Seward and Monde,
Certified Public Accountants

New Haven, Connecticut
March 6, 1952

Balance Sheet, December 31, 1951

GENERAL FUND

ASSETS

Cash		$53,409.65
United States Treasury bonds (market value $16,952.20)		17,000.00
Dues receivable—1951		3,220.00
Accounts receivable—JOURNAL advertising		530.99
Automobile emblems on hand	231.00	
Prepaid insurance	256.00	
Total		$74,647.64

LIABILITIES

Accounts payable:		
JOURNAL	$ 20.83	
Accrued commissions—1951 dues	79 80	
Due to special funds	25.00	
Surplus	74,522.01	
Total		$74,647.64

ANNUAL MEETING FUND

Cash		$13,232.34
Total		$13,232.34
Prepayment—1952 Annual Meeting	$ 2,952.29	
Surplus	10,280.05	
Total		$13,232.34

SPECIAL FUNDS

Gurdon W. Russell Fund:		
Cash	$ 3,480.14	
Securities (market value $7,032.74)	6,750.00	
Due from general fund	25.00	
		$10,255.14
O. C. Smith Trust Fund:		
Principal cash	$ 1,000.00	
Income cash	302.04	
		1,302.04
Building Fund:		
Cash	$ 748.52	
Land	12,270.31	
Building and equipment	76,735.31	
	$89,754.14	
Cash—savings account (funded reserve for depreciation)	2,837.25	
		92,591.39
Clinical Congress:		
Cash		3,430.14
Total		$107,578.71
Grand total		$195,581.19
Gurdon W. Russell Fund—capital		$10,255.14
O. C. Smith Trust Fund—capital		1,302.04
Building Fund:		
Reserve for depreciation	$ 2,837.25	
Capital	89,754.14	
		92,591.39
Clinical Congress—capital		3,430.14
Total		$107,578.71
Grand total		$195,581.19

Statement of Capital
Special Funds
Year ended December 31, 1951

GURDON W. RUSSELL FUND

Balance, January 1, 1951	$ 9,942.07
Add, Interest on savings accounts and bonds	313.07
Balance, December 31, 1951	$10,255.14

O. C. SMITH FUND

Balance, January 1, 1951	$ 1,274.84
Add, Interest received on savings accounts	27.20
Balance, December 31, 1951	$ 1,302.04

BUILDING FUND

Balance, January 1, 1951	$89,522.07
Add, Contributions	337.50
	$89,859.57
Deduct, Expenses of supplies and maintenance not capitalized	105.43
Balance, December 31, 1951	$89,754.14

BUILDING FUND—RESERVE FOR DEPRECIATION

Balance, January 1, 1951	$ 1,405.32
Add, Interest earned	31.93
Transfer from general funds	1,400.00
Balance, December 31, 1951	$ 2,837.25

Statement of Income and Capital
Clinical Congress Fund
Year ended December 31, 1951

Income:

Registrations		$ 1,634.00

Expenses:

Committee meetings	$ 199.19	
Luncheons—net of receipts	50.38	
Speakers	493 94	
Badges	52.15	
Telephone	125.84	
Printing and postage	443.62	
Rentals	342.82	
Clerical assistance	96.00	
Miscellaneous	30.64	
		1,834.58
Excess of expenses over income		$ 200.58
Surplus, January 1, 1951	$ 3,562.52	
Add, Interest earned on savings account	68.20	
		3,630.72
Surplus, December 31, 1951		$ 3,430.14

(Continued)

Healing the human body requires your skill
Healing the body politic requires your will

YOUR VOTE IS VITAL!

So Be Sure You and Your
Family Are Registered —

BE SURE YOU

VOTE!

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. F. Erwin Tracy, Middletown
President-Elect, Mrs. Barnett Freedman, New Haven
First Vice-President, Mrs. Ralph Ogden, West Hartford
Second Vice-President, Mrs. Dewey Katz, Hartford
Recording Secretary, Mrs. Arthur H. Jackson, Washington
Corresponding Secretary, Mrs. Harry C. Knight, Middletown
Treasurer, Mrs. William V. Wener, Norwich

State News

On April 30 the Woman's Auxiliary to the Connecticut State Medical Society held its 8th Annual Meeting at the Hartford Golf Club. The program was devised to carry out some of the Auxiliary objectives by providing a day of sociability, health education and information regarding the work of the Auxiliary. Dr. Perrin H. Long, professor of medicine and executive officer, Department of Medicine of the State University Medical Center at New York discussed the lengthening life span.

Mrs. Howard Root, chairman of the National Revisions Committee, brought greetings from the National Auxiliary and discussed some of its work.

Past presidents of the Connecticut Auxiliary were guests at the luncheon, together with several of the present New England State presidents.

The Woman's Auxiliary was well represented in the Connecticut Medical Society's Art Exhibit at Bulkeley High School. The Exhibit included works by the physicians, their wives and children. Mrs. David Waskowitz, a member artist, gave a concrete example of Auxiliary art work by painting one of the members registered for the luncheon.

County News

HARTFORD

The following officers have been elected for 1952-53 in Hartford County: President, Mrs. Charles E. Jacobson, Jr.; President-elect, Mrs. Reginald C. Edson; First Vice-president, Mrs. Asa J. Dion; Second vice-president, Mrs. Robert Tennant; Recording Secretary, Mrs. George J. Rosenbaum; Corresponding Secretary, Mrs. N. William Wawro; Treasurer, Mrs. Thomas R. Preston; Assistant Treasurer, Mrs. Robert H. Osmond.

NEW LONDON

The Spring meeting of the Woman's Auxiliary was held at Lighthouse Inn on April 3. Mrs. Martin O'Neill of Jewett was installed as president. Other officers elected for the coming year are: President-elect, Mrs. A. G. Ansprenger of Mystic; Secretary, Mrs. Victor E. Smilgin, New London; Treasurer, Mrs. Henry Archambault, Taftville; Corresponding Secretary, Mrs. Joseph M. Wool, New London.

Members of the Auxiliary will serve as hostesses during the New London Tuberculosis Association survey May 2-29.

The Auxiliary passed a recommendation to present an annual money gift to Lawrence Memorial Hospital and the W. W. Backus Hospital to be used for nurses' scholarships and student welfare.

Following dinner, Mrs. Florimond A. Delforge of Norwich presented "Fun With Hats," a fashion hat show. John Gregoropoulos of New London, an artist, discussed the role of color in every day experiences.

President's Health Commission Requests AMA Cooperation

A request for "cooperation" on the part of the American Medical Association in making various health and medical care statistics available to the President's Commission on the Health Needs of the Nation was approved by the Board of Trustees.

Dr. George F. Lull, Secretary and General Manager, officially replied to the Commission, saying: "It has long been the policy of the American Medical Association to permit all survey and study groups to have access to the medical data in its possession. The Board's action, however, should not be construed as implying approval of the Commission or its projected program which we believe to be of political intent."

NEWS
from County Associations

Fairfield

Ralph W. Crane, medical examiner in Stamford for the past 26 years, died at the Stamford Hospital on April 1 at the age of 71. Dr. Crane had practised in Stamford since 1907. He was a past president of the State Medical Examiners Association and a member of the medical board of the Stamford Hospital.

At the regular monthly meeting of the Bridgeport Medical Association held in the auditorium at St. Vincent's Hospital on the first of April, Dr. Eugene E. Clifton, assistant professor of surgery and chairman of the Section on Oncology at Yale University gave an illustrated talk on "Carcinoma of the Pancreas, the Differential Diagnosis and Treatment."

Plans for the establishment of an Outpatient Department at Bridgeport Hospital are progressing and have reached the stage where architects' drawings are being studied for the physical changes necessary for this important step forward. The staff is indebted to the whole hearted cooperation of the administrator of the hospital, Mr. James A. Dunlop. Mr. Dunlop recently was made a member of the Medical Advisory Committee of the Fairfield County Medical Association to the Fairfield County Chapter of the Infantile Paralysis Foundation.

The annual meeting of the Fairfield County Medical Association was held at the Stratfield Hotel in Bridgeport on the afternoon of April 8. Oliver L. Stringfield, president, called the business session of the meeting to order at 4:30 in the afternoon. The association was favored by the presence of the President of the Connecticut State Medical Society, Brae Rafferty; the Executive Secretary of the Connecticut State Medical Society, Creighton Barker; the Chairman of the Council of the Connecticut State Medical Society, Joseph Howard; Jim Burch, Public Relations director of the State Society and delegates from New Haven County Medical Association in the person of Hyman A. Levin and from Hartford County Medical Association, Timothy Curran. Twenty-one new members were added to the roster of the Association at this meeting. Reports were given by the Councilor, Berkley M. Parmelee; the Treasurer, Clifton C. Taylor; the Chairman of the Board of Trustees, Russell A. Keddy; Clifford D. Moore, chairman of the Board of Censors and a few well chosen words by the President, Oliver L. Stringfield. A very important and revealing report was made to the meeting by Frank C. McMahon as chairman of the newly formed Public Relations Committee. Dr. Stringfield as the chairman of the Infantile Paralysis Committee gave a progress report for that committee. John D. Booth head of the Department and Ethics Committee gave a brief report for that body. Officers elected were: President, Isaac L. Harshberger of Bridgeport; Vice-President, Charles S. Knapp of Greenwich; Secretary, Edwin R. Connors of Bridgeport; Treasurer, Clifton C. Taylor of Bridgeport; Councilor, C. Louis Fincke of Stamford, and Alternate Councilor, John P. Gens of Norwalk. New members of the Board of Trustees elected were Alfred J. Sette of Stamford and M. David Deren of Bridgeport. George A. Buckhout of Bridgeport, Franklin S. Dubois of New Canaan and Rector T. Davol of Greenwich were appointed delegates to the House of Delegates of the State Society. Following the business meeting a social hour was enjoyed and the meeting was concluded by a dinner at which one of the largest attendances was recorded. The speaker at the dinner was Alex Raymond, internationally known cartoonist, whose subject was "The Comic Strip in Today's Society."

Hartford

Hartford County Medical Association has joined with the AMA in promoting a new radio health-education series, called "Medicine, U. S. A." A six program series, the documentaries began on March 29 with a story of an alcoholic.

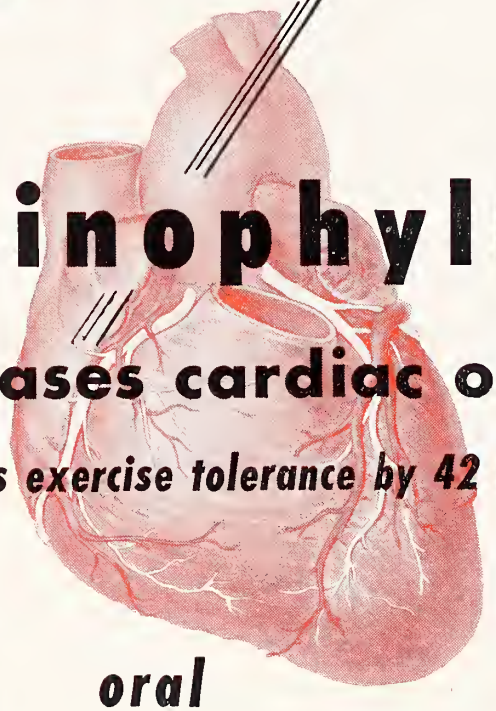
Advertisements, sponsored by the county, appeared in both the *Hartford Courant* and *Times* of March 29, announcing this fact. Retiring president of the county, Dr. James R. Cullen, explained the series on an early morning Saturday broadcast. He said that "Medicine, U. S. A." is not only entertaining but informative as well. He termed the series "one of the very best of its kind."

Editorial matter appeared on the radio page of the *Courant* and the attractive posters sent in the AMA kit have been mailed to over 40 different institutions for display.

In addition, the radio station broadcasting the program, WTIC of Hartford, has agreed to give each of the series a continuing plug for the entire six

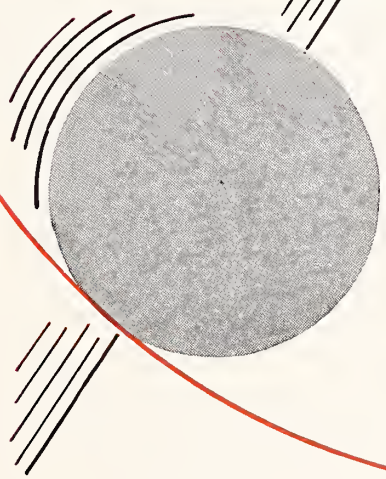
SEARLE

Aminophyllin*



increases cardiac output

"improves exercise tolerance by 42 per cent"[1]



oral
parenteral
rectal dosage forms

Indicated in:

Dyspnea of Congestive Heart Failure
Bronchial Asthma
Status Asthmaticus
Pulmonary Edema
Control of Cheyne-Stokes Respiration

Also of value as: Peripheral Vasodilator[2]

1. Kissin, M.; Stein, J. J., and Adelman, R. J.: Angiology 2:217 (June) 1951.
2. Rickles, J. A. J. Florida M.A. 38:263 (Oct.) 1951.

*Contains at least 80% of anhydrous theophylline.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

weeks, mentioning both the county and the AMA as co-sponsors.

* * * *

Dr. William H. Upson, a Suffield general practitioner for the past 22 years, was elected president of Hartford County Medical Association at its 160th annual meeting in Hartford on April 1. He succeeds Dr. James R. Cullen of West Hartford.

A graduate of Tufts College Medical School in 1927, Dr. Upson is Suffield's health officer and its assistant medical examiner. He is on the courtesy staff at Hartford Hospital.

Dr. Burdette J. Buck of West Hartford was elected vice-president and Dr. Thomas M. Feeney, also of West Hartford, was renamed secretary-treasurer.

Dr. John N. Gallivan of East Hartford was elected alternate councilor and Dr. Harry A. Parlato of New Britain was named to the credentials committee for a three-year term.

Elected delegates to the State Medical Society were Dr. J. Richard Lenehan, and Benjamin L. Salvin of Hartford and R. A. Rica of Glastonbury. Reelected were W. Holbrook Lowell, Jr. of Hartford, Edward Resnik of New Britain and Alfred Sundquist of Manchester.

Discussion on the need for continuing to better public relations highlighted the organization's business session.

Dr. Buck, commenting on the newly organized around-the-clock emergency service, urged more doctors to make themselves available for such service if the plan is to function successfully and achieve its purpose of better service to patients and improve public relations.

"The emergency service is for patients, not doctors," he declared. Physicians can help the service by offering to be available at specific times and arranging "coverage" of their own patients when they are to be away, he said.

Half of the calls to the emergency service, he pointed out, stem from the failure of doctors to provide such coverage. He cited two extreme cases in which the emergency switchboard operator had to call nine doctors in one case and five in another before one could be obtained. While many of the "emergency" calls really aren't emergencies, Dr. Buck said, doctors must realize that the patient is often frightened and must be treated accordingly.

Dr. Cullen, retiring president, joined Dr. Buck in emphasizing the importance of the service. "Doctors have to take these calls if medicine is to move forward." For the most part, however, the service has been operating creditably and was a long step in promoting better public relations, he commented.

Dr. Thomas M. Feeney, secretary-treasurer of the county, pointed out that county membership has reached a new high of 843 members, including the 26 new physicians voted into the county at the meeting.

In his retiring address, Dr. Cullen reviewed the 160 year history of the association from its founding in 1792 by 40 members serving a Hartford of fewer than 4,000 persons to the present time. The Association, he said, has been in the forefront in supporting and extending the best medical thinking of the times.

Today he stated the profession must be alert to put down any attempts to "socialize" medicine through continued explanation to the public of medicine's need for independence if it is to progress.

"We must integrate ourselves into the community and preach as well as practice medicine," he told the county.

A dinner followed at the Hartford Club, at which Francis T. Fenn, Jr. of West Hartford, associate general agent of the National Life Insurance Company and personal estate analyst was principal speaker.

Mr. Fenn, speaking on "Harnessing the Vanishing Dollar," pointed out that last July an act of the Connecticut legislature permits three or more doctors to incorporate either for profit making purposes or on a nonprofit basis—to own and operate a clinic to study and promote medical information and learning.

He declared that under a nonprofit corporation the advantages would be: no heavy corporate income taxes, no question as to the validity of a pension plan qualifying for a tax deduction plus the fact that the doctors can direct surplus monies, which would ordinarily go into tax payments, for medical advancement of an educational and charitable nature.

The savings made by the group are such, Fenn stated, that a business manager can be hired to relieve the doctors of administration, personnel problems and collections. This would free the doctor for more time to specialize and for leisure.

* * * *

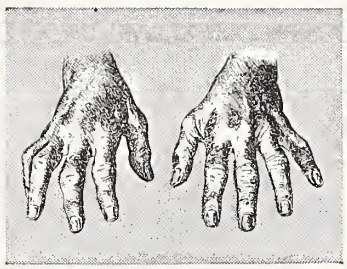
Dr. Charles T. Bingham of Hartford has taken over the position of Physician-in-Charge of the Blue

Cortone®

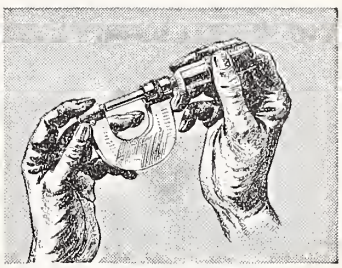
Can Put Your Arthritic Patients BACK TO WORK



INITIAL DOSAGE:
25 mg. four times daily. Consult literature for detailed dosage recommendations.



STEP-WISE REDUCTION:
After moderate relief is established, reduce daily dosage step-wise every three or four days, to smallest suitable maintenance level.



MAINTENANCE DOSAGE:
25 to 50 mg. daily has been found adequate in more than 50 per cent of a series of patients.

Conservative dosage in rheumatoid arthritis provides effective relief—and often may be continued for long periods

Individualized dosage, careful clinical observation, and simple, readily available laboratory procedures (sedimentation rates, urinalyses, blood counts, blood pressure, and frequent weight recordings) are adequate for the rehabilitation and management of most patients.

CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.*

Literature on request

Cortone®
ACETATE
(CORTISONE Acetate Merck)

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

Hill Clinic from Dr. Leonard Losser who resigned to enter private practice.

Dr. Bingham has had wide experience in this field having been identified with the work of the Board of the Commission on Alcoholism since 1947 when he became a member of that board.

In recent years Dr. Bingham has interested himself more and more in the psychological aspects of medicine and has been a leader in highlighting the importance of psychosomatic medicine. He has been active in private practice in Hartford since 1935 with a tour of duty in the U. S. Navy from 1942 to 1946 and with a second stint of 12 months, 1950-1951.

Just prior to taking over his duties with the Blue Hills Clinic on March 10, Dr. Bingham had been acting director of Clinical Services at Rocky Hill Hospital for Veterans and Chronic Illness.

* * * *

St. Francis Hospital has joined the growing number of hospitals with a fulltime director of medical education on its staff.

Since December 1, 1951 Dr. William J. Lahey has been active in that capacity at St. Francis Hospital. He came to his present position from the Veterans' Hospital, Newington, where he was assistant chief of medicine and director of the Cardio-Pulmonary Laboratory. He was and is a clinical instructor of medicine at Yale University.

Dr. Lahey graduated from Harvard Medical School in 1942 after which he interned at Boston City Hospital and then entered the Navy where he served from 1943 to 1946. A year's residency in medicine at the same place from 1946-1947 immediately preceded his position at the Newington Veterans' Hospital.

Dr. Lahey is married and the father of five children.

* * * *

The Hartford Hospital recently announced the appointment of Dr. Theodore W. Steege as assitant medical director to succeed Dr. Daniel H. Deyoe who resigned. Dr. Steege took over his duties on March 3, 1952.

Prior to his appoinment Dr. Steege had been a member of the staff of Hartford Hospital and had been in practice here since 1946.

Dr. Steege's educational and medical background is as follows:

Graduation from Concordia Preparatory School in Bronxville, New York; B.S. degree from Columbia; M.D. from Yale 1938; internship at Strong Memorial Hospital in Rochester; asssistant residency at Lakeside Hospital in Cleveland, Ohio; residency at King's County Hospital, Brooklyn.

Fellowship in cardiology at Presbyterian Hospital in New York. During the war he served in the U. S. Navy and was discharged as Lt. Commander.

Dr. Steege is married and has 3 children.

* * * *

"Bursitis and Myofascitis" by Egmont J. Orbach of New Britain appeared in *The Journal of the International College of Surgeons*, January 1952.

Middlesex

Stanley J. Alexander spent a week at the end of March at the Boston City Hospital where he took a course sponsored by the Boston medical schools. The course was on "The Measurement of Pulmonary Function in Health and Disease."

Christie E. McLeod attended a scientific meeting of the New England branch of the College of Pathology in Boston on March 22.

Tolland

G. Percival Bard, former medical examiner and town health officer of Stafford, died suddenly on April 1 at his home in Crescent, Georgia. Dr. Bard was 79 years old. He retired in 1948 after 47 years of practice, 45 of it in Stafford. At that time he was senior member of the medical staff at Johnson Memorial Hospital, Stafford Springs. Dr. Bard moved to Georgia upon his retirement and had made his home there since.

News from Yale University School of Medicine

Charles Schepens, M.D., D.O.M.S. (London), in charge of Retinal Service, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts, was the guest speaker at the Yale University School of Medicine Post-Graduate Course in Ophthalmology on March 14. His subject was "Retinal Separations." Dr. Schepens reviewed a concept of the mechanism of retinal

Now another important advantage of Thiomerin:

Wyeth®



Suitability for Home Administration

The self-injection of the thionated mercurial diuretic, Thiomerin, has now become a well-established procedure for patients who have congestive heart failure, just as the self-injection of insulin has long been a well-established procedure for patients who have diabetes.

Numerous authorities[1-12] recommend Thiomerin for home administration because it is as well tolerated and predictable in effect when given *subcutaneously*, as when given intramuscularly and intravenously. The technique of injecting Thiomerin Sodium may be quickly mastered.

Consequently, more and more physicians are finding that it is often desirable to instruct the patient or a member of his family in the use of Thiomerin so that injections between visits can be made on schedule—according to the dosage plan that best suits each patient.

A supply of *printed instructions for patients* will be sent to the physician on request.

references:

1. Journal-Lancet 70:298, 1950.
2. Rocky Mountain M. J. 48:99, 1951.
3. Am. J. M. Sc. 218:298, 1949.
4. J. M. Soc. New Jersey 48:12, 51.
5. Am. J. M. Sc. 219:139, 1950.
6. U. S. Armed Forces M. J. 1:332, 1950.
7. Circulation 1:502, 1950.
8. Cincinnati M. J. 31:137, 1950.
9. Southern M. J. 44:44, 1951.
10. M. Times 79:83, 1951.
11. J. A. M. A. 146:250, 1951.
12. Circulation 1:508, 1950.

THIOMERIN®

SODIUM

MERCAPTOMERIN SODIUM WYETH

Council-Accepted Mercurial Diuretic for Subcutaneous, Intramuscular or Intravenous Injection

Wyeth INCORPORATED, PHILADELPHIA 2, PA.

separation and showed a motion picture of his method for localization of tears, and colored still Kodachromes of retinal separations. His surgical treatments were also outlined.

Many questions and comments followed. Alexander Van Heuven, who introduced the speaker, felt that choroidal detachments, following retinal separation were even more frequent than quoted by Dr. Schepens. Eugene Blake asked if Dr. Schepens had ever heard of or seen holes in toxemia of pregnancy. The speaker said he had not. Gregory Flynn asked the order of treatment of a patient with a cataract obscuring a known separation. Dr. Schepens said he would do the separation surgery first and attempt an intracapsular as the second step. Francis P. Guida asked about scleral ectasia complicating separations. Dr. Schepens favored partial thickness removal of the sclera preceded by diathermy before closure.

The meeting was preceded by a clinical case of a peripheral separation that was flat on the first dressing and the patient was therefore permitted to be up out of bed on the sixth postoperative day with a good result.

NEW BOOKS IN REVIEW

A TEXTBOOK OF ORTHOPEDICS WITH A SECTION ON NEUROLOGY IN ORTHOPEDICS. By M. Beckett Howorth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School. In association with: *Fritz J. Cramer*, M.D., *Donovan J. McCune*, M.D., *A. Wilbur Duryee*, M.D., *J. William Littler*, M.D., *Walter A. Thompson*, M.D. *Philadelphia and London: W. B. Saunders Company.* 1952. 1110 pp. with 463 figures. $16.

Reviewed by Denis S. O'Connor

When one opens a new textbook he has great expectations that he is going to find a new clarity of arrangement or a more basic approach to at least some of the subject matter. When one finds a more confused arrangement than usual, an unbalanced treatment of subject matter and unaccepted classification of many subjects, he cannot help but feel that the tremendous labor—which must necessarily go into such a task—has been in vain.

The illustrations, as a whole, are not in keeping with what would be expected in this age of color reproduction which saves the time of the student and more indelibly stamps the anatomic relationships in his mind. Many of the illustrations add nothing to the book and many of the long captions draw conclusions which the illustrations cannot support.

The book is divided into four sections. The first section takes up "The History of Orthopedic Surgery," "Anatomy and Physiology," "Examination and Diagnosis" and "Treatment." "The History of Orthopedic Surgery" covers 18 pages with many photographic illustrations of well known persons in orthopedic surgery, followed by a nine page bibliography. The bibliography could well document a separate volume on this subject. "Anatomy and Physiology" covers fifty pages. It is descriptive without being appropriate to the problems which orthopedic conditions present, and the space might have been used to better advantage by anatomic and physiologic clarification in close proximity to these pertinent orthopedic conditions in which a precise knowledge of the basic sciences would be important to the best handling of the condition. Under "Examination and Diagnosis" too much space is given to general examination, which presumably the student would be expected to get in medical school long before taking up a specialty study. The actual technique of orthopedic examination, which is a crying need in undergraduate teaching, has not been met. "Treatment," covering 74 pages, lacks clarity and good arrangement. It could well be replaced with a chapter on "Orthopedic Techniques."

The second section is entitled "Regional Orthopedics." The first chapter is on "Posture and Obesity." Obesity, certainly, and much of the material on posture could be eliminated without serious loss to the student. The next chapter on the spine devotes much of its space to "Scoliosis," admittedly an important subject but one involved in controversy as to its treatment. The "Low Back," certainly a very important subject for every practitioner of medicine, is inadequately treated and the subject of "The Intervertebral Disc" is turned over completely to "Neurosurgery" in the fourth section of the book. Inasmuch as the problems of the intervertebral disc are largely orthopedic until surgery is necessary and in order that the proper diagnosis and orthopedic treatment in the earlier stages may forestall surgery, it is vitally necessary that not only the orthopedist but the general practitioner be familiar with the interpretation of the low back examination and the orthopedic measures for preventing the episodic protrusion of the disc. The "Shoulder" is covered in one page, the "Elbow" in ten lines and the "Hip" in three pages, while the "Hand and Wrist" requires 50 pages.

The third section covers "Orthopedic Disorders." "Congenital Deformities" requires 100 pages, plus 11 pages of bibliography. It is copiously illustrated with unusual and bizarre congenital skeletal lesions which are very interesting but only of relative value to the student. Orthopedic conditions caused by trauma includes not only "Fractures," "Dislocations and Sprains," but also "Cerebral Palsy" and "Ganglion." While "Cerebral Palsy" and "Ganglion" may be, and probably are, traumatic in origin the trauma is not as obvious as in some conditions and the relative importance of trauma to other factors has yet to be determined. The "Osteochondritides," which are classified under vascular diseases, have far more justification for being considered under trauma. In the 20 pages devoted to "Arthritis" there is little to clarify the student's thinking or understanding of another subject important to every general practitioner. "Tumors of the Spine and Extremities" are



"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

today's health a must!

for your reception room



Physicians' Half-Price Rates

4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

Cove Hill Manor

A Hospital For Neuropsychiatric And Convalescent Care

is a beautifully landscaped ten-acre estate situated between New London and Norwich in historic Uncasville overlooking the Thames River.

ALL therapies are adequately administered by a competently trained psychiatric and medical staff.

FACILITIES are available for mood disorders, alcoholism, psychoneuroses, as well as the arteriosclerotic and senile states. Convalescent care is offered for organic disorders.

Charles M. Krinsky, M.D., D.A.B.
Clinical Director

Rates are available upon request. Write Box 317, Uncasville, Connecticut, or phone Norwich 4-9216.

classified and described under "Tumors of the Skin," "Tumors of the Soft Tissues" and "Tumors of the Skeletal System." Much of the 30 pages is devoted to illustrations.

The fourth section of 200 pages is devoted to "Neurosurgery."

As a textbook of orthopedic surgery this book has very little to recommend it. If it were called "Essays on Orthopedic Surgery and Related Subjects" one could have no objection to it but under that title one would wonder concerning its sales appeal.

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS. Richard J. Plunkett, M.D., Editor, *Adaline C. Hayden,* R.R.L., Associate Editor. Published for American Medical Association. *New York: Blakiston Company.* 1952. 1034 pp. 4 illustrations. $8.

Reviewed by Stanley B. Weld

This is the 4th edition of this valuable nomenclature, the preliminary printing of which appeared in 1932. The original work was initiated by invitation of the New York Academy of Medicine and at that time (1928) the National Conference on Nomenclature of Disease was formed with a membership representing most of the leading medical and public health organizations in the United States. The Standard Nomenclature has brought order out of chaos for librarians, hospital records, secretaries and physicians.

The present volume contains instructions for installation of the nomenclature, a scheme of classification both topographic and etiologic, a nomenclature of diseases and an index to the same, a nomenclature of operations and an index to the same, and an appendix. Several changes have been made in the arrangement of this edition and also many changes have been effected in the scientific material presented. There has been a complete revision of the manner of presentation and diagnostic entries listed under the "Psychobiologic Unit," the section on "Diseases of the Hemic and Lymphatic Systems" and in "Tumor" diagnoses. Altogether, excluding changes concerned with the Inter-

SEND THIS COUPON TODAY
for AVEENO . . . the new concentrate from oatmeal . . . for skin therapy.
Aveeno provides prolonged emallient actian an irritated skin areas . . . cantrals pruritus ani and pruritus vulvae . . . relieves itching and skin irritatian in general rashes, sulfa and penicillin rashes, eczemas and allergic reactians.

E. FOUGERA & CO., INC.
75 VARICK ST., NEW YORK 13, N. Y.
Please send professional samples of AVEENO®.
_____ M.D.
ADDRESS _____
CITY _____ STATE _____



Man-eagle design
from Hopi Indian food bowl

DELICIOUS WAYS TO SERVE LARGE AMOUNTS OF PROTEIN IN LOW BULK

Served in baked goods, custards, puddings, ice cream and other desserts — or in milk —

ESSENAMINE COMPOUND POWDER (with carbohydrate 25%), vanillin flavored — provides the high protein needed by the nutritionally deficient or seriously ill patient, without the bulkiness of ordinary foods. Or Essenamine may be served as a pleasantly crunchy "cereal," plain or with milk, cream or sugar, in the form of

ESSENAMINE COMPOUND GRANULES (with carbohydrate 30%), vanillin flavored

*"With a high protein diet, healing begins on the first day."**

ESSENAMINE®

PROTEIN CONCENTRATE FOR ORAL USE

SUPPLIED IN THREE FORMS:

ESSENAMINE POWDER (unflavored)
7½ and 14 oz. glass jars.

ESSENAMINE COMPOUND POWDER (Vanillin Flavor)
1 lb. glass jars.

ESSENAMINE COMPOUND GRANULES (Vanillin Flavor)
7½ oz. and 1 lb. glass jars.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

*Matthews, J. G.: Care and Healing of Traumatic Wounds. *Northwest Med.*, 50:512, July, 1951

Essenamine, trademark reg. U. S. & Canada

national list, there have been 5,800 changes made in this edition.

The usefulness of this volume speaks for itself, not alone in assisting those engaged in coding and classifying diseases and operations, but also in standardizing the same for the sake of statistical compilations.

UNTOWARD REACTIONS OF CORTISONE AND ACTH. By Vincent J. Derbes, M.D., and *Thomas E. Weiss,* M.D. *Springfield, Illinois: Charles C. Thomas.* 1951. 56 pp. $12.25.

Reviewed by Joseph F. Jenovese

This is a small book, handsomely bound. The material is divided into 11 chapters. After a brief introduction, the physiology of the adrenal-pituitary axis is discussed. This is followed by a discussion of the action of ACTH on the adrenal glands with the resultant production of an excess of circulating Cortisone. The physiologic changes, both therapeutic and pathological, that occur following the use of Cortisone or ACTH are discussed under the headings of the various body systems preceded by a brief outline of the important changes to be observed.

The book is a handy reference, but does not include all of the information that is now known about the untoward actions that may result from the use of these powerful hormones.

DOCTORS IN BLUE. THE MEDICAL HISTORY OF THE UNION ARMY IN THE CIVIL WAR. By George Worthington Adams. New York: Henry Schuman. 1952. 253 pp. 4.

Reviewed by Stanley B. Weld

So many volumes have been written on the Civil War that one is bound to approach such a volume as this with some scepticism. Except for a single chapter or two here and there such as may be found in "A History of the Medical Department of the United States Army," this is the first time an historian has examined the medical practices of that period. It is an illuminating story. Beginning with an account of the Medical Department at the outbreak of the Civil War with its budget of $90,000, its confusion, its poorly trained personnel, its lack of hospitals and the prevailing poor sanitation in the camps, the story relates the rapid expansion and development by necessity and through the vision of a few leaders till at the close of the war there was functioning in Washington a Medical Department headed by a competent Surgeon General. Official standards for surgeons and attendants had been set up and enforced. Specialized infirmaries were established for the care of small pox, "eruptive" fevers, eye and ear diseases, nerve wounds and nervous disorders. The military hospital bed capacity had grown from almost zero to 136,000 and this in less than four years amid a confusion from war for which no preparation had been made.

Surgeon Generals came and went until one was found with courage enough to accomplish the difficult. This was William Alexander Hammond. Army surgeons of various caliber and degrees of ability found their way into the service. Prominent among these was Jonathan Letterman who among other things was responsible for reorganizing the entire supply system, for creating an ambulance system which would function, and for moulding an efficient field hospital organization. Much of the credit for establishing major reform in the Medical Department goes to the United States Sanitary Commission which was created early in the war because of a lay demand for improvement in the care of the sick and wounded. This Commission was instrumental in establishing a hospital diet kitchen service. A new profession of female nurses was formed, due as much to the persistence of Dorothea Dix as to any other individual. The initial pay for these good women was forty cents a day.

The picture is further developed by recounting the story of the surgery accomplished, the use of anesthesia, and the progress in combating sepsis. Bullets, not shells, accounted for most of the battle wounds in one quarter of a million patients of whom 14 per cent died. Cannon balls accounted for only 359 cases and explosive bullets for only 130. Seventy-one per cent of the wounds were on the extremities, only 18 per cent on the torso. A large percentage of those reported killed in action must have bled to death. Bayonet wounds were infrequent since such charges were seldom carried through to the contemplated result. Anesthetic deaths were few. Of 80,000 general anesthetics given, 76 per cent were chloroform. Twenty per cent of all gunshot wounds developed pyemia, erysipelas, or gangrene. Slightly over 97 per cent of these died, an appalling mortality.

The volume is packed with information, statistical and general. As one proceeds from page to page one is impressed by the tremendous job done for our Union soldiers by the surgeons in spite of all their shortcomings and lack of proper facilities. The author might have colored his text with many individual examples and personal accounts buried in the diaries which have survived the struggle. Even so, it is an interesting tale, permeated with all the filth of the poor sanitation of the camps, the horrors of the piles of amputated limbs in the field hospitals, the maggot-ridden hardtack and decomposed meat, and the cries of the wounded being jolted over the rough roads in rickety ambulances. As the sun set at the end of this terrific struggle, the beauty of clean hospitals with uniformed female nurses, diets containing fresh meat and green vegetables, and better than all a conception of what a Medical Department should be shone forth to alleviate to some degree the suffering of many a home in the North.

YOUR VOTE
can help make history

but NOT unless
You've BEEN REGISTERED

Table of Contents : June 1952

Treatment of Anuria Due to Acute Renal Insufficiency
Charles K. Friedberg, M.D., New York City 397

The Medical Importance of Organic Phosphorus Insecticides
Jan Lieben, M.D., Hartford 407

The Narcotics Problem in Connecticut II
The Role of the State Department of Health in its Solution
Daniel P. Griffin, M.D., Bridgeport 408

The Future of Residency Training in Surgery
Gustaf E. Lindskog, M.D., New Haven 410

Hospitals and the Practice of Medicine
From the Viewpoint of the Hospital Trustee 413

Newer Trends in Obstetrics
Herbert E. Schmitz, M.D., Chicago 416

EDITORIALS

Blue Cross, Blue Shield and the Hospital 426
Fairfield County Activates PR Program 427
100 Years of Pharmacy 427
The New England Health Institute 427
CMS Plan for Inhospital Medical Care 427
Hypochondriacs' Heaven 428

DEPARTMENTS

Progress in Clinical Medicine
Intramedullary Nailing of the Femoral Shaft
Ned M. Shutkin, M.A., M.D., New Haven 430
The President's Page 434
The Secretary's Office 435
Connecticut Medical Service 444
Public Relations 454
Military Affairs 461
News From Washington 458
Letters to the Editor 469
Woman's Auxiliary 470
Our Neighbors 480
News From County Associations 480
News From Yale University School of Medicine 484
New Books in Review 485

MISCELLANEOUS

Report of the Poliomyelitis Policy Committee of the Fairfield County Medical Association
Oliver L. Stringfield, M.D., Stamford 429
Annual Reports (concluded) 462
Special Notices 474



Presented at
CMS
Award Dinner
New Haven Lawn Club
May 15, 1952

Achievement Awards to

EUGENE E. GREYTAK

employee of the Patmore Millwork Co , Bridgeport

THE 500,000TH CMS MEMBER

●

FRANK HART

employee of Wallace Barnes Division, Associated Spring Corp., Bristol

THE 23,000,000TH NATIONAL BLUE SHIELD MEMBER

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI JUNE, 1952 No. 6

TREATMENT OF ANURIA DUE TO ACUTE RENAL INSUFFICIENCY

CHARLES K. FRIEDBERG, M.D., *New York City*

The Author. *Associate Physician, The Mount Sinai Hospital, New York*

INTEREST in the treatment of anuria has increased remarkably in the past few years, largely because of the development of new technics and devices which substitute for the nonfunctioning kidneys. At the same time there has been a growing realization that such technics and devices are effective only in transient reversible forms of anuria and that such forms of anuria will usually resolve spontaneously with the proper conservative therapy. Considerable finesse in judgment is required to determine whether a given patient with anuria should be treated conservatively, or whether it is necessary to resort to the use of an artificial kidney or other means of dialysis of the patient's blood.

The physician in private practice, who often first observes the patient with acute renal insufficiency, is burdened by a great responsibility in his choice of therapeutic management. If the disease is self-limited in duration, may the patient be treated conservatively at home until spontaneous recovery ensues? If hospitalization is preferable or essential can appropriate therapy be administered in the local hospital, or must the patient be sent to one which is equipped to employ an artificial kidney? The following discussion is designed to assist the physician in answering these questions with due consideration to the facilities available to him. Whatever choice the physician makes, the treatment he institutes in the first few days is often of critical importance in determining the further course and outcome.

This discussion is not limited strictly to anuria, which denotes a complete absence of renal excretion of urine; severe degrees of oliguria in which the daily output is less than 200 cc. and urea and other metabolites rapidly mount in the blood stream are generally included in discussions of anuria. Actually a daily urinary output of less than 500 cc. denotes serious renal suppression because this is the minimum obligatory amount of urine needed to clear the blood of metabolic products in individuals who are taking no food.

Patients with heart failure, nephrosis or cirrhosis of the liver may, for brief periods during the accumulation of edema, excrete less than 500 cc. of urine daily, but such cases are not included in the category of anuria due to acute renal insufficiency. Obviously retention of urine within the bladder due to prostatic obstruction or to other causes and the absence of urine due to its extravasation within the tissues as a result of trauma are not included under the heading of anuria and are readily distinguishable by the clinical history, physical examination and, if necessary, by intravenous pyelography and cystoscopy. I am excluding from this discussion also the cases of absence of urine due to obstruction of the ureters or renal pelvis by multiple calculi, carcinomatous invasion or surgical injury, because the anuria in these cases is not due to primary inability of the kidneys to perform their function.

When the anuria is due to such mechanical obstructive factors, the treatment is primarily surgical and the objective to remove the obstruction, repair the injury, restore continuity of the urinary passages or to provide a new urinary outlet from the normally functioning kidney, either into the bladder or intestinal tract. It should be apparent that the possibility of such surgical conditions must always be borne in mind before attributing anuria to intrinsic

From the First Medical Service of The Mount Sinai Hospital, New York

Presented at the Clinical Congress of the Conn. State Medical Society and Yale University School of Medicine, New Haven, September 11, 1951

renal disease. In practice this frequently necessitates cystoscopy with ureteral catheterization and retrograde pyelography, unless some nonsurgical cause for the anuria is quite certain from the history and findings.

We are concerned in this presentation with the cases of anuria more specifically due to acute renal insufficiency and associated with intrinsic renal damage. The renal damage may affect predominantly the glomeruli as in acute glomerulonephritis, the proximal tubules as in mercury poisoning or the ascending loop of Henle, distal convoluted and collecting tubules as in the so-called cases of lower nephron nephrosis due to crush syndrome and other causes to be mentioned.[1,2,3] Commonly the tubular lesions are more diffuse and glomerular function may be significantly impaired even when there is no important visible histologic lesion. In Table 1 are listed the causative diseases, agents or factors which are most commonly accountable for acute renal insufficiency resulting in anuria or severe oliguria with extreme azotemia. The responsible mechanisms may be prolonged shock, renal tubular anoxia of varied causation, nephrotoxic agents, or immunologic or allergic reactions which damage the tubules and inactivate their specific excretory functions.[4,5,6]

Table 1

CAUSES OF ACUTE RENAL INSUFFICIENCY WITH ANURIA

1. Crush Injuries
2. Prolonged Postoperative Shock
3. Burns
4. Obstetrical Complications
   - A. Abortion
   - B. Ureteroplacental damage
   - C. Toxemia
5. Hepatorenal Syndrome
6. Intravascular Hemolysis
   - A. Incompatible transfusions
   - B. Transurethral prostatectomy
   - C. Hemolytic toxins
   - D. Blackwater fever
7. Poisons and Nephrotoxins
   - A. Bichloride of mercury
   - B. Sulfonamides
   - C. Carbon tetrachloride
8. Acute Glomerulonephritis

PREANURIC PHASE

Mismanagement has not infrequently resulted from confusion between treatment of the conditions responsible for anuria and treatment of the anuria itself. Once anuria is discovered, which usually denotes established anuria for more than 24 hours, treatment is guided entirely by the presence of acute renal insufficiency and anuria and not by efforts to correct the causative factor. At this stage the anuria is not due merely to shock itself, renal anoxia, etc., but rather to anatomic lesions which can no longer be promptly reversed by correcting the shock or other responsible agent. Transfusions and infusions designed to promote blood flow and nutrition to the kidney will not alleviate the anuria at this stage and may induce serious cardiac failure or fatal pulmonary edema.

We may, however, consider prophylactic treatment of anuria when a patient is observed with a disease which is apt to be complicated by anuria, but before the anuria is established. Then every effort should be made to correct this anuria-producing disease. If shock is present in this preanuric stage, it is not only proper but essential to provide adequate amounts of blood, plasma, saline, or plasma expanders designed to elevate the blood pressure and restore a sufficient cardiac output. Similarly, following mismatched transfusions, but before anuria is established, the administration of large quantities of fluid and alkalis orally and parenterally has been recommended to alkalinize and dilute the urine and thereby prevent the precipitation of hemoglobin or acid hematin crystals in the tubules. It is difficult to determine whether the prevention of anuria may be properly credited to this regimen, since nephrosis with anuria is not an invariable consequence of such transfusion incompatibility. Furthermore, when alkalis are administered in excess, there is danger of renal damage due to alkalosis. One must also distinguish between the anuric and preanuric phase of toxic nephrosis due to chemicals. British antilewisite (Bal) should be administered and is frequently effective prior to the onset of anuria due to mercury.[7]

Occasionally there are borderline instances in which there is uncertainty as to whether anuria is established or whether it may be prevented by treating the causative condition. Transient reversible urinary suppression, occurring in the first twelve hours of shock, and occasionally after twelve to twenty-four hours of shock, may be abolished by the use of blood or other agents designed to raise the blood pressure and to correct tissue anoxia. If this is not promptly effective, or if the anuria has

persisted for more than twenty-four hours, such measures should not be continued. In cases of impaired renal excretion due to dehydration, anuria or oliguria is extremely unlikely to be due to anatomic damage to the kidney. As a rule, reestablishment of urinary flow follows rehydration. Unfortunately, increasing familiarity with the dangers of overloading with fluids in cases of anuria is beginning to lead in some quarters to a misapplied fluid restriction in cases of severe oliguria associated with dehydration, especially following operations, in acute infections and in acute gastroenteritis.

ANURIC PHASE

Once anuria is established, treatment should be based on the following considerations: (1) Renal tubular integrity and major renal functions will usually be restored spontaneously within one to three weeks and therefore nothing should be done during this period which might jeopardize the patient's life.[8,9,10] (2) During the relatively short period concerned many temporary chemical aberrations may occur because of renal impairment but these are rarely dangerous to survival while the therapeutic measures designed to correct these abnormalities may be more hazardous.

It is commonly stated that therapeutic management should aim to maintain water balance, acid base equilibrium, proper nutrition, and to remove excessive metabolic products. However ideal these objectives may be, it is almost always impossible to attain them all simultaneously. The effort to do so is usually responsible for the employment of deleterious therapeutic measures.

FLUID BALANCE

Perhaps the most difficult problem in therapy is the management of fluid balance. The administration of fluids of any kind is always fraught with danger because in the presence of anuria virtually all of the fluid that is administered remains within the body. Consequently there is a constant threat of subcutaneous edema, pulmonary edema and death. Fewer physicians are administering large quantities of fluid parenterally in a futile effort to stimulate renal function and flush the kidneys. On the other hand, when anuria has followed states associated with severe shock or hemorrhage, the urge to correct these latter conditions by transfusions and infusions of large quantities of fluid is still great because of the mistaken idea that even at this stage when the anuria is due to anatomic as well as functional renal damage, the anuria may be resolved by treatment of the original cause. Furthermore, there is a tendency to think that serious consequences have resulted only from massive infusions of fluid. Even moderate intravenous infusions may be dangerous.

A seemingly clear indication for the administration of fluid is the apparent need to replenish such fluids as are lost by insensible perspiration or by vomiting. Since the daily insensible perspiration amounts to approximately 700 cc. or proportionately more under very warm environmental conditions, 700 cc. of fluid is generally permissible in 24 hours. This is given orally by preference, but may be administered subcutaneously or intravenously when there is gastric intolerance. To this is added sufficient fluid to replace the amount lost by vomiting, plus an estimated amount lost by active perspiration in hot climates.

But even these recommendations may be dangerous and require careful consideration. If, as often occurs, the patient is first seen after several days of anuria, and has received anywhere from 2 to 10 liters a day despite anuria, this quantity of fluid must be carefully totalled and regarded as excess body water which could not be eliminated through the kidneys. Even when allowance is made for the insensible perspiration and for the loss of fluid from the gastrointestinal tract during the previous days, one often finds that the excess of fluid administered more than compensates for the insensible perspiration lost during the next three to seven days, and there is no indication for such fluid replacement during that period. This would not of course apply to such patients as were seen in their first day of anuria and who were not given more than the minimal quantity of fluid replacement.

One should also consider that in these cases of anuria the extracellular fluid may be expanded considerably by a shift of water from the intracellular to the extracellular compartment. This may be due in large measure to the accumulation of cellular catabolites in the extracellular fluid since they cannot be excreted, and the consequent shift in fluid may tend to preserve or restore the normal osmotic pressure of the extracellular fluid. Under these circumstances the loss of insensible perspiration would be a desirable outlet for the fluid which is flooding the tissues. The administration of even the moderate amounts of fluid designed to replace insensible loss of perspiration might then be both unnecessary and unwise. It is highly probable that one may have

intracellular dehydration with extracellular overhydration. In the relatively brief period during which we are awaiting restitution of renal function in these cases of acute anuria, there is very slight danger from the intracellular dehydration. But there is grave risk from further extracellular overhydration in an effort to correct the cellular dehydration.

In summary then it is recommended that no fluids be given parenterally and virtually no fluids be given by mouth in patients with anuria who have already been given more than a minimal amount in the previous days of anuria. Up to 500 cc. of fluid may be given orally only if essential to satisfy intense thirst. If the patient is seen on the first day of anuria or if he has been given only minimal amounts of fluid in the previous days of anuria, he may be given the theoretical amount needed to replace insensible perspiration and fluids lost by vomiting provided that there is no edema or other evidence of extracellular fluid increase. The character of the fluids to be given is discussed below.

SODIUM INTAKE

The intake of sodium should be completely interdicted during the period of anuria, even in the presence of hyponatremia, unless it can be demonstrated that the plasma and extracellular volumes are below normal. Although the exact mechanisms for the retention of water in heart failure are obscure, it is well known that the kidney is unable to excrete sodium normally. Nevertheless, this renal deficiency is not complete and many patients with heart failure can ingest 1 to 3 Gm. of sodium chloride daily and excrete all of it satisfactorily. But the kidney of the patient with anuria can excrete no sodium at all. To prevent the manifestations which closely simulate those of heart failure, such a patient must receive no sodium at all.[11] Even if fluids are sharply restricted to minimal replacement, any sodium administered would tend to increase the extracellular fluid by withdrawing fluid from the cells.

The danger of sodium administration in these patients is becoming more generally recognized in theory. Nevertheless, many authors who clearly warn of the danger of administering sodium subsequently mention a number of circumstances which may require the administration of sodium salt, such as hyponatremia, hypochloremia, vomiting or acidosis. Since at least one of these indications is almost always present, and all of them are usually present, the effect of this latter recommendation serves to negate completely the admonition against the administration of sodium salts. A mild hyponatremia is usual in these cases. Its presence produces no significant harm; its correction will not restore kidney function. The administration of sodium does not invariably correct the hyponatremia and is more apt to cause a withdrawal of additional fluid from the cells into the extracellular space, unless large quantities of hypertonic sodium solutions are administered. A moderate acidosis is usual in these cases. Its presence for the week or two needed to await spontaneous recovery is not important in the final outcome; longer periods of similar acidosis are commonly tolerated in cases of chronic uremia. The correction of the acidosis will not restore renal function. The common recommendation that sodium bicarbonate or sodium lactate be administered intravenously to correct acidosis or restore the blood electrolyte pattern is dangerous because of the introduction of the sodium ion.

The plasma chloride concentration is often normal. When hypochloremia is present, it may be due to dilution by retained fluid, to replacement by retained acid radicals and extracellular-intracellular shift as well as to loss in vomitus. There is no evidence that such hypochloremia as is observed in these cases is of more than minor significance. Attempts to correct the hypochloremia by the infusion of sodium chloride encourage the dangers that come with sodium administration in the anuric patient. Correction of the hypochloremia with ammonium chloride is also dangerous because of the intensification of existent acidosis.

Vomiting occurs commonly in patients with anuria. This raises the problem of restoring both the fluid and the electrolytes lost in the vomitus. Much or most of this vomiting would not occur and would offer no problem if overzealous attempts were not made to introduce food and especially fluids. Perhaps the vomiting is a protective device to defend the anuric patient against fluids which he cannot excrete and food whose catabolic end products he cannot eliminate. When a consideration of his water balance in the preceding days of anuria suggest that this is indeed the case, then the vomited fluid need not be replaced. When no excess of fluid has been given previously, such fluid losses may be cautiously replaced. However, it is very rare that the amount of sodium and chloride lost in the vomitus is sufficient to require their replacement. These electrolytes

should therefore not be administered even when it is considered proper to replace the fluid lost by vomiting. An exception may be made only if it can be proven that loss of electrolytes by vomiting has been sufficient not merely to reduce their plasma concentration but to produce a salt depletion shock syndrome with contraction of the circulating blood volume.

DIET

The diet of patients with anuria must be designed in such a manner that it does not enhance the accumulation of waste products since these cannot be excreted. Hence proteins are entirely omitted while preservation of caloric balance depends on the intake of carbohydrates and fats. These foodstuffs must also be free of sodium. With these ends in mind many diets have been devised. Unfortunately gastric intolerance frequently prevents the administration of an adequate caloric intake by mouth, and nutriments must be given parenterally. This requires caution with regard to the amount of fluid administered.

Theoretically, starvation may seem desirable because it imposes the minimal load on the kidneys with respect to water, electrolytes and the metabolic waste products of ingested food. However, in the absence of any food intake, the catabolism of body proteins would provide 15 to 20 Gm. of unexcretable urea daily as well as significant amounts of phosphates, sulphates, potassium and other substances. In terms of blood constituents this would denote a daily rise in the blood urea nitrogen of 15 to 20 mg. or more per day. On the other hand, the administration of 100 to 200 Gm. of sugar daily, by sparing tissue protein, reduces the latter's catabolic product. If sufficient calories can be given in the form of sugar and fat, endogenous catabolism of proteins can be minimized to the point where the daily production of urea does not exceed 10 Gm. daily. Even this, in the presence of anuria, will result in a progressive azotemia with an average daily rise of 10 mg. or more of urea nitrogen per 100 cc. of blood. The protein-sparing effect of sugar has another, perhaps even more important, advantage in that it reduces the accumulation of potassium formed from endogenous protein.

A diet consisting only of 1000 cc. or less of milk, as once employed in the treatment of acute glomerulonephritis with severe oliguria, is unsatisfactory both because of its content of sodium chloride (1.5 Gm. per liter) and of protein (30 Gm. per liter). The Volhard regimen for acute glomerulonephritis consisting of nothing but 800 cc. of orange juice is simple and generally satisfactory, but its content of sugar is somewhat less than optimum for sparing protein; its caloric intake (325 calories) is low and the concentration of potassium in orange juice is moderately high. The first two disadvantages may be partly overcome by fortifying with lactose or sugar, but palatability imposes a limitation in this regard.

The Borst diet[12] of butter balls with a daily intake of 200 Gm. of sugar and 200 Gm. of butter is one which I have found virtually impossible to administer. The Kempner diet of rice, fruits, and fruit juices is only slightly imperfect in its content of about 2 Gm. daily of protein and 200 mg. of sodium, but the fruits and fruit juices are rich in potassium. If one insists on maintaining caloric balance, one soon encounters the disadvantages of small but significant intakes of sodium and protein, of moderately large potassium intake but especially of impalatability, which is serious in a patient who already suffers from gastric intolerance. For practical purposes it is preferable to compromise in the direction of an inadequate caloric intake rather than permit the ingestion of more than the minimum of sodium.

Some of these problems are solved by providing nutriments subcutaneously or intravenously. But it is difficult to obtain an adequate caloric intake without the jeopardy of excessive amounts of fluid. If no more than a liter of fluid is given intravenously in the form of 10 per cent glucose, only 400 calories a day are provided. If the intravenous administration of fatty emulsions becomes more practical, this may help solve the problem. Recently 1 liter of 40 per cent dextrose daily, providing 1600 calories was administered for 28 days by means of a cardiac catheter introduced by way of a vein and left in situ.[13] However, in this instance thrombosis around the catheter resulted in embolization which caused or contributed to a fatal outcome. Nutriments have also been supplied by an indwelling gastric tube, through which a mixture of dextrose and peanut oil emulsified in water may be administered.[14]

In summary, the dietary intake consists essentially of glucose, lactose, sugar or, if there is no hyperpotassemia, small amounts of fruits and fruit juices, given in such a manner as not to exceed the maximum fluid allowance as stated above. If tolerated, supplements of rice, potatoes, flour, butter and peanut oil may be given, but in general one must accept an

inadequate caloric intake in order to reject more than the extreme minimum of sodium and protein. Vitamin supplements should be given orally or parenterally. When oral feeding is impossible, feeding by nasogastric tube or the intravenous administration of 10 to 50 per cent glucose may be necessary, but the permissible amount of fluids should not be exceeded.

The Use of Renal Substitutes

Despite the expectation that spontaneous recovery will occur within 1 to 3 weeks with conservative therapy, it would seem theoretically preferable if normal excretion and normal bodily homeostasis could be maintained without risk during this period of waiting, by means of some artificial excretory device or technique. Furthermore, not infrequently the clinical state of the patient becomes extremely precarious due to the anuria or the therapy and it becomes highly desirable or necessary to employ such devices or technics to eliminate toxic substances which have accumulated or to readjust serious aberrations in fluids or electrolytes.

In order to accomplish these ends, four general methods have been used: (1) the artificial kidney; (2) peritoneal dialysis; (3) intestinal perfusion; and (4) exsanguination transfusion. Indications for their use are not clearly defined because they are not always without risk, and one cannot be certain which cases justify this risk in order to assure survival. While it has been impossible in human cases of acute anuria to say whether recovery occurred spontaneously or was due to the use of an artificial kidney or dialysis, there is no doubt that the latter devices have served to prolong life in the experimental animal after bilateral nephrectomy far longer than would occur spontaneously.[15,16]

In general these special procedures are either indicated or should be carefully considered in cases of acute anuria (1) in the presence of hyperpotassemia (perhaps above 7 mEq/L), (2) in the presence of serious overhydration or congestive heart failure, (3) very pronounced elevation of urea nitrogen (perhaps exceeding 180 mg. per 100 cc.), (4) severe acidosis producing clinical manifestations. As the risk of using the artificial kidney is becoming minimized, it may be proper to employ it in less critical circumstances than those listed.

The artificial kidney

The artificial kidney[17,18,19] consists essentially of cellophane tubing which serves as a dialyzing membrane, across which various nonprotein solutes diffuse into a fluid surrounding the cellophane tubing. The blood is conveyed from an artery through the tubing, which has a large dialyzing surface and which is immersed in bath fluid of a carefully predetermined composition. On leaving the artificial kidney the blood is pumped into flasks which serve as traps for clots and air and is returned by gravity to the patient's vein. Numerous improvements and modifications have been designed,[16,20,21,22] particularly with the view to obtaining a large dialyzing surface with as small a volume of blood in the apparatus at one time as possible, maintenance of a low concentration of metabolites in the bath fluid, optimum blood flow, simplicity of construction and ease of repair and sterilization. Clotting in the system has been minimized by the use of heparin and of improved tubing. Hemolysis is prevented by maintenance of a slightly higher osmotic pressure in the bath fluid than that of the blood. With a blood flow of 125 to 250 cc. per minute over a period of three to seven hours, blood urea nitrogens ranging between 75 and 120 per 100 ml. have been reduced to between 30 and 90. This denotes a removal of 25 to 65 Gm. in terms of urea nitrogen. Despite various improvements, use of the artificial kidney still presents the problems of a relatively complex apparatus and the need for a skilled staff to operate it.

peritoneal dialysis[23]

The peritoneum represents an excellent diaylzing membrane with an extensive filtering surface which has been calculated to be about 22,000 sq. cm. and therefore comparable to the filtering surface of the renal glomeruli. By irrigating the peritoneal cavity with the proper fluid, toxic and metabolic substances present in excess in the blood are drawn into the peritoneal lavage fluid and removed. The shift of water and solutes across the peritoneal membrane depends on the relative concentration of various solutes in the peritoneal irrigating fluid as compared to their concentration in the blood. By irrigating with hypertonic solutions, water may be drawn out of the extracellular fluid, while toxic and metabolic substances present in excess in the blood may be drawn into the peritoneal lavage fluid if those toxic or metabolic substances are absent or present in lower concentration in the lavage fluid than in the blood.

Generally two openings into the peritoneum are made for inflow and outflow tubes, respectively, and a continuous flow of 1 to 3 liters per hour main-

tained. A total of 20 Gm. of urea is usually removable per day. Despite many modifications and additions, and despite the recovery of some 21 cases in the first 100 thus treated,[24] the method was essentially unsatisfactory because of the frequency of infection, and the difficulty of maintaining a satisfactory flow. Renewed interest in peritoneal lavage has recently been stimulated by the report of Grollman and associates[25] that bilaterally nephrectomized dogs could be maintained in good condition for periods of 30 to 69 days by means of a method of intermittent peritoneal lavage. As applied to humans with anuria, the method involves introduction of the lavage fluid and drainage at two hour intervals through a single opening in the anterior abdominal wall. A trocar is introduced as for removal of ascites, the stylet is replaced with a polyethylene plastic tube and the trocar removed. The plastic tube remains in place during the procedure and is connected alternately through a needle to an adapter and rubber drainage tube and to the infusion bottle. Aseptic technic and antibiotics in the lavage fluid are designed to prevent infection.

PERFUSION OF AN INTESTINAL LOOP

Removal of excessive metabolic and toxic substances from the blood by irrigation of the colon through an appendicostomy tube has proven ineffective. While irrigation of the small intestine appeared theoretically more promising, difficulties arose in the introduction and maintenance of multilumen Miller-Abbott tubes. Recently Twiss and Kolff[13] reported that with the aid of small intestinal dialysis a patient survived for 46 days after removal of the only functioning kidney. Urea balance was maintained for this long period by dialysis on 16 consecutive days. A loop of small intestine 2.5 meters long was isolated by transverse sections and the ends brought out through lateral abdominal stab wounds, with the vasculature intact. Continuity of the remaining intestine was restored by end to end anastomosis. The isolated loop was perfused with fluid passed through a Murphy drip and thermostatically controlled bath to bring the fluid to body temperature.

It is important to recall that the intestinal wall is not comparable to the cellophane tubing of the artificial kidney or the peritoneum as a dialyzing membrane. The intestinal wall is an actively absorbing surface and there is a danger that the introduction of large quantities of fluid and electrolytes will lead to their absorption and to heart failure.

EXCHANGE TRANSFUSION

By virtually simultaneous introduction and removal of 12 to 15 pints of blood in the adult anuric patient, about 80 per cent of the patient's original blood can be removed. This method is designed to withdraw excessive and toxic substances by replacing pathologic blood with normal blood.

The amount of urea removed by exchange transfusion is substantially less than by the artificial kidney and there is little or no reduction in azotemia. Nevertheless, satisfactory diuresis and occasionally a dramatic improvement have been observed following this procedure in patients with anuria.[26,27,28] This has been attributed either to the removal of unidentified nondialyzable substances not eliminated by dialysis technics, or to the beneficial effect of introducing normal blood. Of course the difficulty of distinguishing a spontaneous from a therapeutic recovery in cases of anuria is well known.

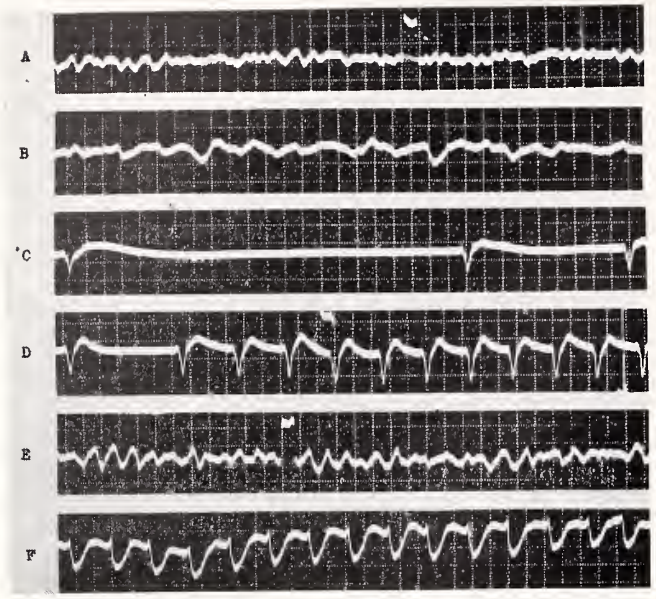
The appeal of this method lies in its comparative simplicity and availability as contrasted with the artificial kidney and with the need for entering the peritoneal cavity in the other dialysis technics. On the other hand large quantities of blood are required and there are the well known dangers inherent in multiple blood transfusions. Because of the danger of increased serum potassium in stored blood, fresh blood should be employed in such transfusions. Failure to take this precaution may have accounted in part for the unhappy consequences in a case of anuria following septic abortion, as indicated in Table 2 and in the electrocardiographic tracings (Figure 1).

Table 2

HYPERPOTASSEMIA FOLLOWING EXCHANGE TRANSFUSION

	K	Na	Cl	HCO_3	Urea N	Creatinine	P
	(m.Eq. per liter)				(mg. per 100 ml.)		
Normal	4.5	140	104	27	15	1.5	4
Before Transfusion	4.7	133	99	16	120	11.0	8
After Transfusion	8.4	140	105	16	110	19.0	11

Following the exchange transfusion, the patient's serum potassium was elevated above 8 mEq/liter; she developed marked intraventricular conduction disturbance, episodes of ventricular flutter and ventricular standstill, and Adams-Stokes syndrome, and she died before diuresis was established.



Hyperpotassemia in Acute Anuria. Segments of a continuous strip over a 5 minute period. A and B, Ventricular fibrillation. C. Ventricular standstill. D, Ventricular tachycardia, rate 130. E, Ventricular flutter-fibrillation. F, Intraventricular block with ventricular tachycardia

LAVAGE FLUIDS

Lavage fluids of varied composition have been used,[29] depending on the technic used and the individual problems in a given case. The composition of some of the irrigating solutions recently used in the artificial kidney (Merrill et al),[30] in peritoneal lavage (Grollman et al),[25] in lavage of the isolated intestinal loop (Twiss and Kolff),[13] as compared with Ringer's solution and normal blood plasma is represented in Table 3. It will be noted that the solutions used in the artificial kidney and for peritoneal lavage are either isotonic or very slightly hypertonic to blood. The osmolarity of these solutions relative to the patient's blood may be checked by determining the depression of the freezing point. On the other hand, intestinal irrigating solution is made strongly hypertonic by the use of hypertonic glucose solutions or preferably by less absorbable hypertonic solutions of sucrose or magnesium sulphate. To avoid sodium absorption, the intestinal irrigating solution contains much less of this ion than blood or the other dialyzing solutions or preferably no sodium at all. The concentration of electrolytes or other solutes may be modified according to special needs. In the presence of hyperpotassemia, the dialyzing solutions may serve to withdraw potassium from the blood if they are free from potassium. Acidosis may be corrected by increasing the concentrations of sodium bicarbonate in the irrigating fluid above 2 Gm. per liter. By using very hypertonic glucose in the dialysis fluid, water may be withdrawn if the patient is edematous.

TREATMENT OF HYPERPOTASSEMIA

Hyperpotassemia in acute anuria is probably the best defined indication for the use of the artificial kidney[30] or other dialysis procedures.[31] These procedures must be considered whenever serum potassium exceeds 7 mEq/Liter, but this indication should also be interpreted in conjunction with clinical[32] and electrocardiographic[33] evidence of potassium intoxication. Tall pointed T waves and prolonged QT interval are the earliest evidence of hyperkalemia and in themselves may not be sufficient reason for use of the artificial kidney. However, more advanced electrocardiographic changes, such as prolonged low or absent P waves, prolonged PR interval, low R waves with deep S waves and depressed RST segments and intraventricular block, are evidence of more severe potassium intoxication. If uncorrected they may lead to ventricular flutter, fibrillation or standstill. Other clinical manifestations are less precise. There may be complaints of muscular weakness, with or without obvious loss of power, progressively more intensive hyperkalemia characterized by flaccid paralysis of the extremities, loss of reflexes and

TABLE 3

COMPOSITION OF BATH OR IRRIGATING SOLUTIONS

	NaCl Gm./L	KCl Gm./L	$NaHCO_3$ Gm./L	$CaCl_2$ Gm./L	$MgCl_2$ Gm./L	Glucose Gm./L	Sucrose Gm./L
Bl. Plasma	5.8	0.3	2.0	0.30	0.10	1.0	
Artif. Kidney[30]	6.6	0.3	2.25	0.40	0.10	2.0	
Perit. Lavage[25]	5.77	0.2	3.0	0.20	0.05	1-50	
Intest. Lavage[13]	0-1.5	0-0.4	1-2.0	0-0.28		0-30	60-80
Ringer's Solu.	9.0	0.3	0.2	0.25			

eventually impaired phonation and respiration caused by weakness of the musculature involved.[32]

Various conservative forms of treatment of hyperkalemia are ineffective, particularly in the presence of anuria. Transient benefit may follow the use of glucose and insulin infusion given with the minimal amount of fluids. The use of cation resin is still experimental as a means of removing potassium.[34] When hemodialysis by the artificial kidney is designed to correct hyperkalemia, potassium is omitted from the bath fluid. At the same time the correction of acidosis may assist in diminishing potassium shifts in the cell to the extracellular fluid. As much as 4 or 5 Gm. of potassium may be removed in the dialyzing fluid. Not infrequently clinical and electrocardiographic improvement following hemodialysis may occur with only slight or moderate reduction in the concentration of potassium. This may be due partly to incomplete correlation between the electrocardiographic changes and the concentration of potassium or to a dependence of the electrocardiographic changes on associated metabolic disturbances (sodium concentration, acidosis) as well as on the degree of hyperkalemia.[35]

TREATMENT OF HEART FAILURE AND PULMONARY EDEMA

These complications should not occur if the admonitions previously mentioned are properly considered. If acute pulmonary edema does occur, it may have to be treated with opiates, phlebotomy and administration of oxygen. However, if promptly available, dialysis with strongly hypertonic glucose solution may be undertaken. Diuretics are contraindicated. Digitalis is probably of limited value but should be administered in the presence of heart failure. Cedilamid by injection or digoxin orally are preferred.

POSTDIURETIC PHASE

After diuresis has begun, fluids may be given orally as desired. Rarely correction of the electrolyte pattern may be needed due to excessive excretion. However, this should be undertaken only after careful study of the electrolyte pattern of blood and urine and careful measurement of fluid balance.

SUMMARY

1. The treatment of anuria due to acute renal insufficiency is discussed with reference to conservative management and the use of the artificial kidney and other technics which substitute for renal excretion.

2. Conservative therapy is almost always preferred because spontaneous recovery usually occurs in one to three weeks.

3. If the patient is observed early, and if excessive fluids have not been administered and there is no edema, 700 cc. of fluid may be given daily plus the amount necessary to replace fluids lost by vomiting or excessive perspiration. Preferably the fluids should be given orally.

4. If after the establishment of anuria the patient has received substantially more than this allotment of fluid, or if edema or pulmonary congestion is present, no fluid should be given parenterally and not more than 500 cc. by mouth, until the excess of administered fluid has been eliminated by insensible perspiration and vomiting.

5. The dietary intake should consist of glucose, lactose, sucrose or if there is no hyperpotassemia small amounts of fruit or fruit juices, in quantities not to exceed the above allowance of fluid. If tolerated, supplements of rice, potatoes, flour, sweet butter and peanut oil may be added. Hypertonic glucose (10-50 per cent) may be administered intravenously or the above mentioned foodstuffs may be given by nasogastric tube.

6. The artificial kidney and other renal substitution technics should be employed chiefly for dangerous hyperkalemia and occasionally in cases of pulmonary edema, congestive heart failure, severe clinical acidosis or extreme degrees of azotemia. These indications may be liberalized with simplification and increased availability of renal substitution devices and elimination of risk in their usage.

BIBLIOGRAPHY

1. Lucké, B.: Lower nephron nephrosis (the renal lesions of the crush syndrome of burns, transfusions and other conditions affecting the lower segment of the nephrons), Mil. Surgeon 99:371, 1946.

2. Malgraith, B. G., Havard, R. E., and Parsons, D. S.: Renal syndrome of wide distribution induced possibly by renal anoxia, Lancet 2:293, 1945.

3. Gaberman, P., Atlas, D. H., Kammerling, E. M., Ehrlich, L., and Isaac, J.: Renal anoxia syndrome: A review and report of 22 cases, Ann. Int. Med. 35:148, 1951.

4. Corcoran, A. C., and Page, I. H.: Crush syndrome: posttraumatic anuria. Observations on genesis and treatment, J. A. M. A. 134:436, 1947.

5. Bywaters, E. G. L.: Renal anoxia, Lancet 1:301, 1948.

6. Van Slyke, D. D.: The effects of shock on the kidney, Ann. Int. Med. 28:701, 1948.

7. Longcope, W. T., and Luetscher, J. A., Jr.: The use of BAL (British Anti-Lewisite) in the treatment of the

injurious effects of arsenic, mercury and other metallic poisons, Ann. Int. Med. 31:545, 1949.

8. Kugel, V. H.: Management of acute toxic nephrosis, Am. J. Med 3:188, 1947.

9. Strauss, M. B.: Acute renal insufficiency due to lower nephron nephrosis, New England J. Med. 239:693, 1948.

10. Stock, R. J.: Acute urinary suppression. Observations in twenty-two patients, Am. J. Med. 7:45, 1949.

11. Friedberg, C. K.: Congestive heart failure of renal origin. Pathogenesis and treatment in four cases of carbon tetrachloride nephrosis, Am. J. Med. 9:164, 1950.

12. Borst, J. G. G.: Protein Katabolism in uraemia; effects of protein-free diet, infections, and blood transfusions, Lancet 1:824, 1948.

13. Twiss, E. E., and Kolff, W. J.: Treatment of uremia by perfusion of an isolated intestinal loop, J. A. M. A. 146:1019, 1951.

14. Bull, G. M., Joekes, A. M., and Lowe, K. G.: Conservative treatment of anuric uremia, Lancet 2:229, 1949.

15. Seligman, A. M., Frank, H. A., and Fine, J.: Treatment of experimental uremia by means of peritoneal irrigation, J. Clin. Investigation 25:211, 1946.

16. Vanatta, J., Muirhead, E. E., and Grollman, A: Improvements of the artificial kidney: an experimental study of its application to dogs bilaterally nephrectomized or otherwise deprived of renal function, Am. J. Physiol. 156:443, 1949.

17. Kolff, W. J.: New ways of treating uremia, London, J. & A. Churchill, 1947; The artificial kidney, J. Mt. Sinai Hosp. 14:71, 1947.

18. Alwall, N.: On the artificial kidney, Acta med. Scandinav. Suppl. 229:1, 1949.

19. Murray, G., Delorme, E., and Thomas, N.: Artificial kidney, J. A. M. A. 137:1596, 1948.

20. Skeggs, L. T., Jr., and Leonard, J. R.: Studies on an artificial kidney, I. Preliminary results with a new type of continuous dialyzer, Science 58:427, 1948.

21. Merrill, J. P., Thorn, G. W., Walter, C. W., Callahan, E. J., III, and Smith, L. H., Jr.: Use of the artificial kidney, J. Clin. Investigation 29:412, 1950.

22. Rosenak, S. S., and Saltzman, A.: A new dialyzer for use as an artificial kidney, Proc. Soc. Exper. Biol. and Med. 76:471, 1951.

23. Fine, J., Frank, H. A., and Seligman, A. M.: Treatment of acute renal failure by peritoneal irrigation, Ann. Surg. 124:857, 1946.

24. Snapper, I.: Management of acute renal failure, Bull. New York Acad. Med. 25:199, 1949.

25. Grollman, A., Turner, L. B., and McLean, J. A.: Intermittent peritoneal lavage in nephrectomized dogs and its application to the human being, A. M. A. Arch. Int. Med. 87:379, 1951.

26. Bessis, M.: The use of replacement transfusion in diseases other than hemolytic disease of the newborn, Blood 4:324, 1949.

27. Snapper, I., and Schaefer, L. E.: Treatment of two patients with hepatorenal syndrome and acute renal failure by exsanguinotransfusion, Ann. Int. Med. 34:692, 1951.

28. Dausset, J.: Lower nephron nephrosis: report of treatment of 44 patients by repeated replacement transfusion, Arch. Int. Med. 85:416, 1950.

29. Odel, H. M., Ferris, D. O. and Power, M. H.: Peritoneal lavage as an effective means of extrarenal excretion, Am. J. Med. 9:63, 1950.

30. Merrill, J. P., Smith, S., III, Callahan, J., III, and Thorn, G. W.: II. Clinical experience. The use of an artificial kidney, J. Clin. Investigation 29:425, 1950.

31. Hicks, M. H., Crutchfield, A. J., and Wood, J. E.: Intestinal lavage in the potassium intoxication of lower nephron nephrosis, Am. J. Med. 9:57, 1950.

32. Finch, C. A., Sawyer, C. G., and Flynn, J. M.: Clinical syndrome of potassium intoxication, Am. J. Med. 1:337, 1946.

33. Keith, N. M., Burchell, H. B., and Baggenstoss, A. H.: Electrocardiographic changes in uremia associated with high concentration of serum potassium, Am. Heart J. 27:817, 1944.

34. Elkinton, J. R., Clark, J. K., Squires, R. D., Bluemle, L. W., Jr., and Crosley, A. P., Jr.: Treatment of potassium retention in anuria with cation exchange resin. Preliminary report, Am. J. M. Sc. 220:547, 1950.

35. Merrill, J. P., Levine, H. D., Somerville, W., and Smith, S., III: Clinical recognition and treatment of acute spontaneous potassium intoxication, Ann. Int. Med. 37:797, 1950.

THE MEDICAL IMPORTANCE OF ORGANIC PHOSPHORUS INSECTICIDES

JAN LIEBEN, M.D., *Hartford*

The Author. *Industrial Hygiene Physician, Department of Health, State of Connecticut*

ORGANIC phosphorus insecticides are highly toxic to many insects and form one of the most efficient weapons of the commercial grower against several agricultural pests. They are far more efficient than D.D.T. and other older insecticides and their use is becoming ever more popular.[1] The sales of T.E.P.P. (tetraethylpyrophosphate), H.E.T.P. (hexaethylpyrophosphate), and parathion (diethyl p-nitrophenyl p-thiophosphate) have increased rapidly during the past three years. In this State they are used principally against tobacco and greenhouse pests.

However, their efficiency against insects is accompanied by high toxicity for warm-blooded animals including man. One death and two cases of severe illness caused by organic phosphorus insecticides have come to the writer's attention in this State and several other cases have been reported from outside. Several airplane crashes of insecticide sprayers have been blamed on the poisons.[2] Each of the Connecticut cases and most of the others, could have been prevented if the proper precautions had been taken. The toxicity of organic phosphorus insecticides to the produce consumer is negligible if applied in accordance with the manufacturer's instructions. Residues are lost rapidly.[3] Most of the loss is due to the volatility of the chemical, but plant growth and weather are also factors.

CASE 1

A greenhouse sprayer became comatose approximately 40 minutes after finishing spraying and had to be admitted to hospital. He recovered under atropine treatment.[6]

CASES 2 AND 3

Two children were admitted to hospital unconscious. Their room had been sprayed with parathion from an aerosol fumigant bomb. One child died in a hospital despite atropine treatment; the other one recovered. The parents stated they had found the bomb and used it to rid their house of vermin.

SYMPTOMS AND SIGNS OF POISONING

The organic phosphorus insecticides act on the autonomic nervous system. Blurred vision, headache, contracted pupils, abdominal cramps, tightness in the chest, diarrhea, nausea are prominent symptoms. Sweating, myosis, tearing, salivation, coma, loss of sphincter control are the spectacular signs.

LABORATORY FINDINGS

The activity of the blood and plasma cholinesterase is measured and low values have been accepted as indicative of exposure. However, there has been considerable discussion of the reliability of the test and it is used only because of the absence of better tests. Last year Mountain[4] of the U. S. Public Health Service reported that excretion of paranitrophenol followed absorption of parathion and this test is now under consideration. However, many factors as relating to time and quantity of this excretion test are still unknown.

TREATMENT[5]

Remove the individual immediately from area of insecticide application. If skin contact has occurred, wash immediately with soap and water. If symptoms occur, remove patient to hospital. Atropine is the antidote, 1/60 of a grain every hour up to 30 tablets hypodermically until pupils dilate. The acute emergency lasts 24 to 48 hours and the patient should be under continuous observation. Accumulation of pulmonary secretion may require postural drainage. Muscular weakness may cause respiratory distress and an oxygen tent and artificial respiration may become necessary.

PREVENTION

The nature of the poison should be known to those applying it. Organic phosphorus insecticides can cause symptoms through ingestion, inhalation, and absorption through the unbroken skin.

From the Bureau of Industrial Hygiene, Department of Health, State of Connecticut

Protective clothing is essential to avoid skin contact. It includes boots, overalls, gloves and hat. An approved respirator will prevent inhalation. Should skin contact occur, immediate thorough washing with soap and water is essential.

The cholinesterase activity varies and in order to have a better understanding in case of poisonings, a base line should be available for each person prior to exposure to the agents.

The Bureau of Industrial Hygiene of the State Department of Health is equipped to perform cholinesterase and paranitrophenol tests and will advise on proper preventive measures. Together with the Department of Agriculture, the Department of Aeronautics, and Board of Fisheries and Game, it also handles the licensing of insecticide spraying from the air. It will give consultation on preventive programs which should include a base line and periodic blood cholinesterase prior to exposure.

Although organic phosphorus poisons are highly toxic, their intelligent handling and early treatment of poisoning will prevent further occurrence of fatal casualties.

REFERENCES

1. Easter, S. S.: Agricultural Control Chemicals Advances in Chemistry, Series I, American Chemical Society, Washington, D. C., April, 1950, p. 5.

2. Sullivan, R. R.: Presented at Industrial Hygiene Section, A.P.H.A., Seventy-ninth Annual Meeting, San Francisco, California, October 31, 1951.

3. American Cyanamid Co., Growers Handbook, February, 1951.

4. Mountain, J. T., Zlotolow, H., O'Connor, G. T.: Industrial Health Monthly, 11:88 (1951).

5. Technical Development Services, Communicable Disease Center, U.S.P.H.S., Clinical Memorandum, March 2, 1950.

6. Three years of study of Organic Phosphorus Insecticides, Occupational Health, Federal Security Agency, March 1952.

THE NARCOTICS PROBLEM IN CONNECTICUT II

The Role of the State Department of Health in its Solution

(From a Report to the Committee on Mental Health, Connecticut State Medical Society)

DANIEL P. GRIFFIN, M.D., *Bridgeport*

THE first section of this account (CONNECTICUT STATE MEDICAL JOURNAL, February 1952) considered the existence and extent of the problem as viewed by Federal officials and supported by statistics supplied by their experiences. These authorities emphasized the need of support from State agencies to effectively control the extensive and varied manifestations of the social evil presented by the abuse of these drugs.

Connecticut has long been alert to this danger. In 1935 its legislature passed the State Uniform Narcotic Drug Act and now, seventeen years later, it is one of only five states which have an enforcement agency developed to apply its terms.

The Bureau of Preventable Diseases under the direction of James C. Hart, M.D., M.P.H., is the unit concerned with offenses against the State law. For the past five years, it has employed two full time narcotic agents. The present officers are Mr. Robert C. Grieb and Mr. Glenn C. Rivard. These men work in close cooperation with Mr. Edward A. Murphy, the Federal Agent whose territory includes Rhode Island and western Massachusetts as well as Connecticut.

Naturally the Bureau is not exclusively concerned with the detection of abuses and the acquisition of evidence which will lead to arrest. Indeed, the prevention of addiction by supervision of distribution is one major objective. Another is to arrange for adequate institutional care for those persons identified as addicts. Dr. Hart feels that the Federal figures do not represent the incidence of addiction, but rather the relative failure of therapy and the resultant arrests.

There is much work to be done and the following table of activities gives one an impression of its extent and variety:

Summary of Field Trips
Bureau of Preventable Diseases
Division of Narcotics

PURPOSE	JULY 1 TO DEC. 31 1950	JAN. 1 TO JUNE 30 1951	TOTAL
Analyses of drugs	6	5	11
Conferences and meetings	1	12	13
Court trials and hearings	22	32	54
Inspection of wholesalers and manufacturers of narcotic drugs	4	45	49
Investigation of drug addicts and suspected drug adicts	127	296	423
Marihuana investigations	20	30	50
Miscellaneous	29	17	46
Receipt of old narcotic drugs	32	21	53
Talks	3	28	31
Visits to druggists and institutions regarding narcotic drugs	691	420	1111
	935	906	1841

The Bureau's function is not primarily punitive, but preventive and supervisory, so a larger number of contacts may be anticipated by this agency than by a Federal officer. The figures are interesting. I quote from the Bureau's records:

"During the last fiscal year our files show that 128 persons were investigated on suspicion of being drug addicts. Of these, 11 arrests were made under the state law and 18 under the federal law. Drugs causing addiction were divided as follows: demerol 18, morphine 19, heroin 25, dilaudid 6, codeine 6, cocaine 2, paregoric 3, pantopon 9 and use of marihuana 5. These figures represent 84 addicts, of whom 7 had multiple addiction; in addition, 27 persons were investigated who were 'medical addicts,' that is, were taking drugs for adequate medical reasons under proper supervision. The number of medical addicts is, of course, greater than our figures indicate, since many are identified on prescription and not investigated further by our workers."

The special problem of the use of drugs by minors has received close attention. Three cases of the use of heroin turned up in Hartford during 1951. All were mildly affected; none had developed physical dependence on the drug.

In January 1952, a number of young people were picked up by the Hartford police. Statements of these individuals implicated others and a good many members of the whole group including eleven minors were reported to have smoked marihuana. This did not appear to be a major interest of theirs, but among their older contacts were five suspected of using heroin and fourteen others said to have used marihuana. Some aspects of this situation are still under investigation as this is being written.

One important activity of the Bureau is in the field of education. A little known Connecticut law reads as follows:

(General Statutes of Connecticut, Revision of 1949, Volume I, Sec. 1358) "Effect of alcohol and narcotics to be taught. The effect of alcohol and narcotics on health, character and citizenship shall be taught to pupils above the third grade in the public schools; and, in teaching such subjects in grades above the fifth, text-books and such other materials as are necessary, shall be used. This section shall apply to classes in ungraded schools according to the grades designated herein. Teachers colleges shall give instruction on the subjects prescribed in this section and concerning the best methods of teaching the same."

In the first section of this report attention was drawn to the sharp difference of opinion expressed by authorities about the wisdom or necessity of lecturing to young people still in school on the subject. In Connecticut the possible risk of exciting adolescent curiosity by classroom discussion has been very carefully considered. It has been decided that the opinion of competent educational authorities about the details of such a program should be decisive.

Naturally the existing situation has created a widespread public demand for dependable information about the character of this problem and the best means of preventing its development. These appeals have reached the Bureau of Preventable Diseases and the State Department of Education. These two agencies have cooperated in responding by supplying speakers, furnishing educational materials and forming a special joint committee on narcotic education. A folder on the subject of addiction has been prepared and nearly five thousand copies of this have been distributed in recent months. It contains only twenty-one paragraphs, yet it omits no essential data. For those officially or professionally interested in the problem, the Bureau has a valuable file of dependable statistics and a collection of confiscated drugs, as well as the devices—often quite primitive—used for preparing, inhaling or injecting them.

Public concern is also reflected in the severe penalties imposed by the 1951 revisions of the Uniform Narcotic Drug Act passed by the Connecticut legislature. A second offender may not receive less than a sentence of five years imprisonment, while the minimum sentence for a third offender is now ten years. To sell or offer to a minor any narcotic drug carries a penalty of not less than fifteen years.

Physicians, of course, are more directly concerned with the development or maintenance of addiction by means of prescriptions. An important task of the Bureau has been the systematic inspection of the records of narcotic registrants. The value and necessity of employing these drugs in medical practice is clearly understood, but the risks involved are also recognized. Patients who suffer from persistent or recurrently severe pain may require relief over prolonged periods and dependence, especially in susceptible or sensitive individuals, is readily acquired. In certain painful and incurable conditions where the need for the continued use of narcotics is obvious and justified, the patient may be regarded as a legal medical addict.

In other cases, the original pathological condition may at length be cured or substantially improved while a new problem has been created by the pain-relieving drugs. On this account, the physician, faced with the necessity of employing these agents over some period of time in a given case, must be equally concerned about the necessity of reducing the dosage and discontinuing the drug as soon as it is safe to do so. The grim fact that addiction may develop in as brief a period as three weeks from the daily use of a narcotic is not adequately recognized. And, occasionally, it appears we need to be reminded that morphia is a good analgesic, but a poor hypnotic. Surely its employment in the treatment of insomnia not due to pain is rarely justified.

Not infrequently prescription blanks are stolen, physician's names are forged and pseudoemergencies are created by addicts in their efforts to obtain drugs. Dr. Hart says, "The careless use of narcotics by professional people has too frequently resulted in tragedy which could easily have been prevented."

In summary, it may be said that Connecticut is keenly aware of the character of the problem reviewed in this report. Its Departments of Health and Education, as well as its law enforcement agencies, are working in harmony to control it. The Bureau of Preventable Diseases as an integral part of the State Department of Health is deeply concerned in maintaining and improving our enviable record in this direction.

I wish to express my sincere thanks to Dr. Hart and the members of his staff for their courteous cooperation in assembling the data for this report.

THE FUTURE OF RESIDENCY TRAINING IN SURGERY

Gustaf E. Lindskog, m.d., *New Haven*

Almost without exception the men who are entering surgery as a specialty today are products of the graded residency system, having progressed from an internship to a senior residency appointment during a period of five or more years in some university teaching center or in a large community hospital. What these men represent in terms of professional ability and accomplishment is due in great measure to the opportunities provided by that system and its training methods which Halsted first introduced into America from the German universities at Johns Hopkins Hospital around the turn of the century.

This residency training system has prospered and spread, probably beyond the fondest hopes of its early proponents. Its familiar virtues gave it vitality and should ensure its permanence. If any final proof of intrinsic worth is needed, it was given on the

Remarks of the retiring president at the Annual Meeting of the Connecticut Society of American Board Surgeons, New Haven, December 13, 1951

battlefields and in the military hospitals of World War II, both in the Atlantic and in the Pacific areas, where young American surgeons established a truly remarkable record.

The indispensable core of this training system lies in free access to, and ready availability of, case material for major operations, operations to be performed in sufficient number by the surgical trainee according to his skills and his stage of development under adequate teaching supervision.

Today, or in the near future, that type of training program stands in jeopardy of contraction and deterioration because in most centers throughout this country the customary sources of ward-type case material are shrinking. In our own hospital, while the total operative material remains quite stable or even increases steadily in certain categories, there is a decrease in the ratio of ward to private type cases. From the hospital administrators' and credit office standpoint, this is a most welcome trend, but to surgical teachers it is a cause for grave concern.

For the instruction of the undergraduate student, and in large measure for the intern, private and semiprivate patients can serve at least as well as the ward category for history taking, physical examinations, instruction in pre- and postoperative care, and for teaching rounds. They may indeed be superior in many respects. But these cases are less valuable for the intermediate residents, and can be of little or no consequence to the senior resident unless we are prepared to modify our present attitudes toward their management and disposition.

The observed trend toward reduction in ward category cases is based on a number of factors. First and foremost is the steady growth of surgical insurance such as Connecticut Medical Service and private or industrial insurance plans. In Connecticut, Connecticut Medical Service only four years after its inception has grown to include 450,000 subscribers, and dependents, or approximately one-fifth of the population of the State.

Second is the marked transformation in quality of medical care afforded by the Veterans Administration hospitals, particularly those affiliated with medical schools through the dean's committee system since 1946. This improvement together with an explosive increase in the total veterans' population to over 13 million, and a very liberal interpretation of the public law which extends hospital and medical benefits for nonservice connected disabilities, has shifted a significant fraction of the civilian medical load in the direction of this federal agency. But it must be pointed out at once that this shift has been compensated for from the standpoint of teaching by the establishment of 34 Board approved residencies in surgery at these veterans facilities, mostly of the highest quality. These 34 residencies represent 15 per cent of 224 hospitals approved for complete surgical programs in this country.

Third is the establishment and growth of smaller medical centers in community hospitals of 100 to 250 beds located in numerous small cities throughout this State and the nation, each staffed in part at least by highly competent and well trained products of our residency training system. The majority of such hospitals are too small to support a complete residency training program according to the criteria established by the certifying board. While this multiplication of minor centers may be highly desirable and is seemingly entirely justified by the needs and convenience of the local communities, it inevitably reduces the amount of case referral to larger teaching medical centers, especially in the general surgical and medical fields.

Fourth is the restrictive admitting policy practised by many hospitals with respect to elective ward general surgical cases, when bed shortages hamper the admission even of revenue producing private and semiprivate cases. These bed shortages are the result of many factors such as growth in population, increased use of hospitals, the misapplication of the hospitalization insurance plans for diagnostic study, an inadequate basic financial support, and last but not least a diminishing supply of student and graduate nurses.

Fifth is the increasing trend to specialization in surgery, and the splitting off of ancillary special services from the parent stem.

None of the five factors enumerated above will in our opinion cease entirely to be operative in the predictable future; any or all may grow in relative importance.

We must admit as beneficiaries of the residency training system, unless we be devoid of gratitude and totally oblivious of our country's future needs, that the system must not only be preserved but indeed expanded somewhat for a growing population, which after several more decades will total nearly 200 million.

A proper balance in a training program for surgical residents requires an assignment of time about evenly distributed among (1) general ward surgery

with its free access to active operative experience and direct responsibility, (2) private surgery, and (3) the surgical specialties which in our experience have a high percentage of private cases. The pressing question is, how is this balance to be preserved? Only partial answers can be given now.

Obviously, 13 million veterans, and the enormous voting bloc which they control insure that the Veterans hospitals are here to stay and are going to increase in scope and level of professional competence. They are already drawn into the university teaching medical programs in many areas, and this integration must be reinforced by planned assignment of students at both undergraduate and graduate (residency) levels. The same can be said for the smaller community hospitals. The latter are in general unable to maintain a complete residency program on their own initiative. Their resources must be supplemented. They must be brought, where the spirit is willing and the local interest already exists or can be developed, into a coordinated rotational residency exchange program based on the larger regional centers as teaching, standardization, and procurement nuclei.

However, these measures alone are not enough. Both the regional centers and the smaller community hospitals will have to resolve somehow the problem of a diminishing ward-to-private ratio, as it exists already or is bound to develop except in a handful of giant metropolitan institutions and the federal hospitals. That borderline economic group which, without hospital and medical service insurance, would automatically be classified as medically indigent must be made available again for the residents' training. Human nature being what it is, it is not realistic to expect that a practising surgeon, young or old, will often relinquish his opportunity for a guaranteed surgical fee, no matter how modest its level in comparison with higher private practice fees. The resolution of this conflict in interests is not easy, but I venture to predict that the pressure of future events will require some compromise not by indirection or subterfuge but openly and legally arranged. The private surgeon who practises individually or as a member of a private group clinic and the university surgeon acting for a medical school center must in the future be enabled to take the responsibility for such borderline insurance cases, to supervise the operative work and postoperative care by a resident or junior colleague, and thereafter be enabled to collect the professional fee as established in the contract either for himself, his group clinic or his medical school as the case may be. I can see no justification for the hospital as such to participate financially in this relationship because the hospital interest in domiciliary and medical service functions and the surgeons' responsibility for professional care are not identical and are best separated.

The Connecticut Medical Service and similar regional plans of insurance have in the recent past and may, we hope, continue in the future to provide substantial bulwarks against the persistent forces promoting socialization of medical practice. But the price of this defense must not be the destruction of the surgical profession at its roots.

Practising and teaching surgeons have a strongly compelling, indeed a moral obligation to devise and implement some original method for maintaining a proper supply of operating case material and making it freely available to resident trainees in surgery in order to save the training programs and the very system which has given birth to our high national level of professional competence and is nurturing it to maturity.

HOSPITALS AND THE PRACTICE OF MEDICINE

From the Viewpoint of the Hospital Trustee

(The following is an excerpt from a talk presented at the 53rd Annual Convention of the American Hospital Association, St. Louis, September 17, 1951, by Mr. Robert Cutler, Boston; President and Trustee, Peter Bent Brigham Hospital; Director, Hospital Council of Metropolitan Boston; President, Old Colony Trust Company.)

The modern hospital is no longer a workshop for individual doctors. It is a field for team play. And the team play is directed not towards the Trustees or the Administrator or the doctors or the aggregate entity called "hospital," but towards the Patient who is King.

Now it is against the backdrop of these principles, if I may call them such, that I wish to comment upon two aspects of the controversy which has been stirring over what is called the "exploitation" by hospitals of the specialists in radiology, pathology, and so forth.

I shall not rehearse the history of this matter, which is abundantly (extravagantly, I might put it) documented. I can join in deploring the heat and clamor of the fray—the presence of too much vinegar and the absence of enough honey.

Where there are abuses, where there is exploitation, where there is short sightedness, they are not to be condoned but are to be corrected. But they can be better corrected if we call a spade a spade and attribute a malady to the true motivating cause.

Two positions, in particular, have been advanced frequently as somehow being the key to this troubled relation between the voluntary hospital and the specialist on its staff. One of these positions is expressed in legal terms. The other is placed upon ethical grounds. It seems to me that neither of these lines of argument is sound, and that they confuse more than they clarify.

In the first place, it is said that for a hospital to collect and retain all or part of the fees earned by a doctor on its visiting staff for services performed within the hospital, meanwhile paying to the doctor a salary which is less than the net profit of his work, is to constitute the practice of medicine by the hospital. And, the argument runs, no hospital can be licensed to practice medicine; only individuals may be so licensed.

Now this argument, while stated with legal profundity, overlooks the basic concept of corporation law. Here I am speaking to you as a lawyer. I practiced law actively for twenty years, was a partner in a large metropolitan law firm, and for two years was Chief of the Law Department of the City of Boston. While War Service and Banking may have rusted my legal equipment somewhat, I hope still to have retained my grasp of the fundamentals with which for two decades I earned my bread and butter.

A hospital is a corporation. It is a corporation chartered by the sovereign State to care for the sick, in its Wards and in its Outpatient Department and even in their homes. How is a corporation to care for the sick? In 1612, in "The Case of Sutton's Hospital" (10 Co. Rep. 1, at 32b), the Court pointed out that "a corporation aggregate of many is invisible, immortal, and rests only in intendment and consideration of law . . . (The corporation) cannot commit treason, nor be outlawed, nor excommunicated, for (it) has no soul, neither can (it) appear in person, but by attorney." This quaint and ancient language expressed in modern dress would read like this:

"Corporate powers and purposes can only be expressed and performed through natural persons acting as its officers and agents. They are the means, hands, and heads by which corporations normally act." *(Hunt v. Stromberg Motor Devices Co.,* 215 Mich. 483 (1921).

A hospital cannot care for the sick, as the State charters it specifically to do, with bricks and mortar, with machines and equipment, with drugs and gauze, with syringes and thermometers. There must be human hands and hearts and intelligences. There must be aides and nurses and general doctors and

Reprinted in part from the Westchester Medical Bulletin, January 1952

special doctors. The corporate hospital acts by and through these human beings to perform its charter powers. And the acts which they thus perform do not constitute the practice of medicine by the hospital in the sense in which that term is used with reference to the licensing of an individual any more than an act which I do, in bringing to bear my professional legal knowledge on some matter in the Trust Company's behalf, constitutes the practice of law by the Trust Company.

Let us explore this simile a little together. A trust company, like a hospital, is a corporation. Each fulfills and exercises its corporate powers through agents. The hospital acts, in part, through professional doctors. The Trust Company acts, in part, through professional lawyers. Old Colony Trust Company has on its staff four members of the Massachusetts Bar, whose entire duties are to advise the Trust Company with reference to legal questions affecting it in the carrying out of its charter powers. This employment is entirely legal and practically necessary. These gentlemen are lawyers of excellent standing—in fact, one of them is treasurer of the Boston Bar Association and another serves on a standing committee of the Association. The advice which they give to the Trust Company is legal advice, for which they are paid a salary; but the giving of such legal advice by agents of the Trust Company does not mean that the Trust Company is practicing law.

In fact, it is a criminal offense in Massachusetts for a trust company to practice law. This prohibition nicely points the difference. The corporate trust company may rightly employ a lawyer as its agent to advise it with reference to its business and thus carry out its charter powers. What it may not do is to employ a lawyer as its agent to advise others on legal questions, for that is ultra vires, beyond its powers.

So I say that, in my opinion, quite clearly it is proper for a hospital to employ doctors to act as its agents in carrying out its charter powers; and such employment does not constitute the practice of medicine by the hospital. Such employment merely constitutes the fulfillment by the corporation of its charter purpose in the only way in which that purpose can be fulfilled.

The method of compensating the agent does not affect this basic concept at all. Whether the doctor is compensated on a salary basis or on some other basis that is agreeable has nothing to do with the exercise of corporate powers, nor can it make such exercise proper or improper. The quantum and quality of compensation is a matter between the principal and the agent and should be settled by them on whatever basis will appear reasonable and equitable.

The second of the positions to which I have adverted asserts an ethical basis. It contends that it is unethical for a professional man to accept from a hospital a salary for his services, the value of which may well exceed the salary payment.

Unless there is some peculiar sanctity in the profession of a doctor that differentiates him from the lawyer or the minister, which I do not believe, this line of argument strikes me as no more cogent than that which we have just explored.

When I first graduated from the Harvard Law School and was admitted to the Massachusetts Bar, I was employed by one of the leading law firms of our State. It was a large office, with ten partners and some twenty "juniors" as we youngsters were called. We "juniors" received a salary—and mighty glad we were to have it, too. Whether the salary was more or less than we were worth depended on the quality and quantity of the work done by a particular junior. When I later became a partner of the firm, I was of the opinion that after the first year or so of natural floundering the juniors returned to the firm more value than they were paid. But neither the juniors nor the partners—nor anyone else—thought this unprofessional or unethical. The junior had a fine office in which to work; he had an unending stream of work fed to his yawning beak for nourishment; he had close association with leading members of the Bar, rich chance to observe how each partner tackled, analyzed and surmounted a succession of difficult intellectual problems. With these factors properly weighed, a junior may well have owed the firm—I know many of us genuinely felt our indebtedness for this early training and guidance.

It will be said that the junior law clerk is like the interns, the house officer, the resident; and that during a training period there is no unethicality in a salary arrangement because in that interval the "quids" balance out the "quos." The crux comes, it will be said, when the law clerk is admitted to the law partnership, when the resident in the hospital becomes pathologist or radiologist or chief or assistant in some other hospital specialty.

Well, I find a difference in relation but not in kind. After I was admitted to parntership in my law firm, I received annually an amount which was agreed upon with my consent by my senior partners. Some years it was more than what I earned, net after my share of expenses; in other years, it was less. It never occurred to me to figure that I should be compensated in terms of what I contributed to the pot, net; or to feel aggrieved and unethically dealt with if my net share might be less than I earned.

For one reason, I felt a deep pride which could never be compensated by money in being a partner of so many fine and intelligent men. The stimulation of that common association, the obligation to be worthy of it in the best professional tradition, was measurable only in terms of prestige and honor. I felt a debt to my partners which could only be discharged by the constant exercise of the best talents that I had. Is not this indeed the quintessence of ethical relations?

In the second place, we partners were concerned for our firm, for its standing, for the rounded service which it could offer to clients. We were competent in many fields—taxation, corporate reorganization, labor law, probate and trust work, and so on. Not all these fields were as profitable as others; but we wished to provide to our clients a "whole service," capable to solving all their problems. So we were ready and eager to build the firm in strength, widely and deeply; and thought more of the reasonable satisfaction of all partners who made up our firm than of whether each received back his exact net contribution.

In fact, the partners were more apt to quarrel that they were paid too much rather than too little. I remember one partner, who was earning in six figures, refusing for over three months to cash a check for his final share for the prior year because it was in his opinion too large.

I press home this simile because I have been a professional man most of my life and see nothing unprofessional or unethical at all in taking, by agreement, a salary or share that is less or more than one has earned, net, in a given period. In fact, I rather think the high plateau of professional living is the one where the enthusiasm for the enterprise and one's associates in it transcends and minimizes the financial aspect. It is a pretty poor kind of professional ethics that thrives only in terms of dollars and cents received. On his seventy-third birthday old Thomas Alva Edison said:

"This country would not amount to as much as it does if the young men of 50 years ago had been afraid they might earn more than they were paid."

From what I have said, I draw this conclusion:

In ethical and professional and moral matters it is often difficult, if not imprisoning, to lay down from central authority general rules to be followed by all people everywhere, or else. You can't legislate morality. Standards of conduct can be preserved by voluntary agreement where a law would be flouted. So here, I say, a general rule or law relative to the employment by hospitals of specialists would fly in the face of experience.

Each community has its own problems of climate and economics and competition and race and creed. Conditions that prevail in a New Hampshire town of 10,000 with a small community hospital of 20 beds have no reasonable basis of comparison with conditions prevailing in a great medical and teaching center like Boston with 6 general beds per thousand of metropolitan population. The problem will differ in each community and should be settled at that best informed level, according to the best interests not only of the profession and the hospitals in that community, but especially of the public in that community. I trust to the men and women of good will in each community to work out reasonable and equitable solutions.

Do not mistake me. Of course there are people less than good in every community. There will be exploiters, if you will. But these can be best met and overcome by freedom of action and good will at the local level rather than by forcing every community into a Bed of Procrustes.

NEWER TRENDS IN OBSTETRICS

HERBERT E. SCHMITZ, M.D., *Chicago*

TODAY'S activities associated with the dedication of the Bishop McAuliffe Obstetrical Pavilion of St. Francis Hospital recall the fact that up until comparatively recent times the Christian Church bore almost alone the entire burden of establishing and maintaining such institutions as hospitals, asylums, orphanages and homes for the incurably afflicted. As Father John O'Brien has said, "The Church is a tender and loving mother who has reached her arms out through society in every age and has gathered to her nourishing breasts the poorest and the most afflicted of all God's children." Communities of men and women were organized to staff these institutions and to dedicate themselves by sacred vows to a lifelong ministry to the sick. Again quoting Father O'Brien, "These mighty institutions of charity, mercy and benediction, which Christianity has bequeathed to civilization, constitute the monumental evidence of the earnestness with which the Church has sought in all ages to hearken to the words of Christ when he said, 'By this shall all men know that you are my disciples, if you have love one for another'." What could be a greater tribute to God than the thousands of babes so dear to him that are to be born in these magnificent surroundings and cared for by the devoted Sisters and outstanding medical staff.

On such an occasion as this it is fitting that we review trends in obstetrics. By recalling what has transpired, we may be better able to anticipate the future trends in our specialty. With the physical equipment afforded you in this modern lying-in hospital, the safety of mother and infant is assured, if improvements in technique are kept abreast of the improvements in the physical plant.

It seems fantastic that as recently as 1841 the now revered Ignaz Philipp Semmelweis was being ridiculed and reprimanded by Professor Klein, head of the obstetrical section of the General Hospital of Vienna, for his theory relative to the cause of puerperal fever. At this time 12.24 per cent of the mothers delivered in the first and second clinic succumbed to this dreaded complication of childbirth. It was common practice in those days for the accoucher to leave the autopsy room and without even washing his hands to attend a mother in labor. When Kolletschke, an intimate friend and colleague of Semmelweis, died of cadaveric poison contracted through a finger injury sustained while performing an autopsy on a mother who had recently died of childbed fever, the idea came to him that infection was the cause of both deaths, and that by thorough washing of the hands and the use of an antiseptic solution such deaths might be avoided. When, however, he attempted to introduce such a procedure in the clinic, he was scorned by the students and advised by his superior to give up such childish practices. When he persisted, he was dismissed from the hospital. It took years of constant crusading to entirely abolish childbed fever and gain recognition for Semmelweis and the adoption of his methods. The mortality rate in these same wards dropped to 1.27 per cent in 1848; thousands of mothers had been saved.

Since this time further lowering of the maternal mortality has been effected throughout the world by equally important discoveries. Maternal mortality rates in the United States are expressed by the National Office of Vital Statistics in terms of the number of maternal deaths per 10,000 live births. These rates, as listed in the International Vital Statistics, are expressed in terms of the number of maternal deaths per 1,000 live births.

A review of the statistics reveals that there has been a dramatic reduction in maternal mortality

Presented at the dedication of the Bishop McAuliffe Lying-in Pavilion, St. Francis Hospital, Hartford, Connecticut, March 12, 1951

From the Department of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University, and The Lewis Memorial Maternity Hospital

since 1930. There were 6.40 deaths per 1,000 live births in 1930, as compared with only 1.57 deaths per 1,000 live births in 1947.

It has been noted that those States with the highest maternal mortality figures also have the largest number of nonwhite births. In 1946 the mortality rate of nonwhite mothers was three times that of the white mothers. Inadequate medical attention, poverty and dietary deficiencies are a few obvious factors causing this discrepancy. Statistics from the Federal Security Agency indicate that the lowest mortality rates are encountered in mothers between twenty and thirty years of age. This is also the reproductive period when the outlook for the baby is optimum.

Factors of note in the decline in maternal mortality are (1) improvement in medical education, (2) increase in the number of hospital deliveries, (3) blood banks, and (4) antibiotics.

The number of infant deaths is expressed by the National Office of Vital Statistics as deaths per 1,000 live births. The term infant deaths is used to include both the infant deaths prior to birth and those which occur within one month after birth; stillbirths and neonatal deaths.

Approximately one half of the neonatal deaths occur within the first day of life, prematurity being the most important single cause.

There has been a gradual decline in the infant death rate from 1935 to 1946. Potter and Adair pointed out that a thorough and painstaking analysis of every fetal and neonatal death would do much to improve the fetal salvage.

Infection

Effects of asepsis, technique and newer drugs

Much has been done in the last three decades to improve the lot of the pregnant mother. DeLee was probably the first to advocate a more active approach to obstetrics. His teachings have done much to lessen the wear and fatigue of labor and the damage and injury to mother and child that can accompany normal labor. Part of the improvement in fetal mortality and morbidity may be credited to the use of prophylactic forceps and episiotomies. Prior to the advent of the episiotomy, ragged and contused lacerations of the perineum were of frequent occurrence. Such lacerations were difficult to repair properly, and as a result their healing was imperfect. This added to the patient's discomfort and increased the incidence of morbidity. A clean-cut episiotomy has circumvented this difficulty, as such an incision can be repaired easily. Kamperman points out that it is as important to follow the same aseptic technique

Table I

Maternal mortality

(International Vital Statistics)

	1920	1930	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947
U. S. A.	8.0	6.4	5.8	5.7	4.9	4.4	4.9	4.0	3.8	2.6	2.5	2.3	2.0	1.5	
Canada			4.9	5.6	4.9	4.2	4.2	4.0	3.5	3.0	2.8	2.7	2.3		
France				2.1				1.8	1.8	1.6					
*England			4.3	4.0	3.5	3.1	3.2	2.7	2.9	2.6	1.9	1.6			
Eire			4.7	4.7	3.6	4.1	3.4	3.7	3.2	2.5	2.3	2.4			
Italy			3.0	3.0	2.7	2.4	2.3	2.2	1.9	1.8					
Sweden			3.1	3.1	3.1	2.4	2.3	2.2	2.0	1.6	1.5				
Brazil			2.7	8.2	8.7	7.7	6.8	7.4	7.5	6.6	6.5	6.2			

	1927	1947
Illinois	7.0	1.0

*Mortality ratio from England excludes all deaths from abortion

Table II

Increase in hospital deliveries in U. S. A.

1935.....37 per cent births in hospitals
1941.....61 per cent births in hospitals
1946.....82 per cent births in hospitals

Table III

Infant mortality

(National Office Vital Statistics)

	1935	1937	1942	1943	1944	1945	1946
U. S. A.	32.4	51.0	40.0	40.0	39.2	38.1	24.0
Sweden			29.0				
England			49.0				
Canada			54.0				
Eire			68.0				
France			70.0				

for vaginal deliveries and episiorraphy as is carried out for any major surgical procedure.

Since DeLee's original paper, many other new techniques have come to the fore and have helped to further reduce the incidence of morbidity and complications of the obstetrical patient.

Early ambulation has had a beneficial effect in reducing the incidence of thrombophlebitis and phlebothrombosis. Adamson, and many other investigators, have recently published reports on the use of Dicumoral in the prophylaxis and treatment of phlebitis in the pregnant and parturient woman. They have found no untoward results in the prudent use of this drug and thus have hastened the recovery and reduced the morbidity of the patients affected with these disorders. Many surgeons, as we in our group, have been advocating the use of high saphenous and multiple vein ligations in pregnant women who have severe varicose veins, thus eliminating the possibility of one source of embolus. Hamilton, Pittam and Higgins reported on 591 pregnant patients treated between 1938 and 1948. They had good results in all but four per cent of their patients. They stress that early vein ligations during pregnancy are safe and, most important of all, the fact that none of these patients had a postpartum phlebothrombosis or thrombophlebitis.

The use of intravenous pitocin for the induction of labor and in uterine inertia has been an important step forward in modern obstetrics. The prudent use of this drug has helped eliminate the more difficult and traumatic midforceps deliveries. This reduces the amount of soft tissue trauma and the excessive drain on the vitality of the prolonged labor patient. Stone of New York University reported on the use of greatly diluted pituitrin intravenously in prolonged labor. He reduced the number of hours of labor considerably by the administration of this drug. He points out the tremendous advantage of the use of pituitrin by this method in that the obstetrician has complete control over the amount present in the blood at all times.

The establishment of blood banks and the more liberal use of blood transfusions have aided in the more rapid recovery of patients, who some years ago might have sustained a postpartum infection because of their poor nutrition. The use of intravenous fluids aid in maintaining an adequate fluid balance in prolonged labor patients. Most modern obstetrical hospitals have a more rational approach to the management of the protracted labor cases. We refer to this management as the "Shane" method: namely, sedation, hydration, antibiotics, nutrition and elimination.

As mentioned above, all deliveries are done under the same sterile conditions that would be used for a surgical procedure. Quite recently, however, a new germicidal agent has been incorporated into a liquid detergent, which is now being commonly used for surgical scrubs, and it has been advocated for routine use by the nurses in the newborn nurseries. This substance is hexachlorophene. Many recent articles have proven that a surgical scrub with a three per cent solution of this substance in a liquid detergent is far superior in reducing the bacterial count on the human skin than the ordinary liquid soap.

In 1935, with the introduction of the sulfa drugs, the hazard of infection, with a high maternal and fetal morbidity and mortality rate, was greatly reduced. Since then, such antibiotics as penicillin, streptomycin, aureomycin, chloromycetin and terramycin have widened the spectrum of bacterial and viral infections which may be combated successfully.

Sulfadiazine still remains the drug of choice in the treatment of many urinary tract infections. Beacham and coworkers state that ordinarily one out of every fifty pregnant women have an occurrence of urinary tract infection. They suggest careful inspection of the urine of every pregnant patient in an attempt to diagnose and treat subclinical infections early. Such cases should be treated with sulfadiazine and, if acute urinary infections should arise, penicillin in conjunction with sulfadiazine should be used. Infections with such organisms as escherichia coli, proteus vulgaris, aerogacter aerogenes and other Gram negative bacteria can usually be controlled with streptomycin. Many of the serious sequela will be avoided by proper therapy, thus arresting pyelonephritis and possibly preventing the development of hypertension.

Syphilis has become less hazardous to the pregnant mother and child since the beneficial effects of penicillin have been discovered. Diagnosis and treatment of syphilis in the early months of pregnancy have resulted in a ninety-four to ninety-five per cent rate of deliveries of normal infants according to Wammock, Carrozzino and Ingraham. This is a marked improvement over the old-time treatment with bismuth and arsenic preparations.

Many interesting publications have shown the beneficial effects of penicillin on the elimination of puerperal fever. Keettel and Plass recently studied

a series of cases using prophylactic penicillin on some postpartum patients and nothing at all on other patients. The morbidity rate of the controlled group in their study was 6.4 per cent; whereas in those cases receiving penicillin the rate was only 1.3 per cent.

Observations by Guilbeau, Schaub and Andrews revealed that penicillin therapy will usually disinfect the postpartum uterus. In their series, cultures of the material obtained from the uterine cavity of thirty out of thirty-two patients, who had received no antibiotic therapy, were positive. Uterine cultures were sterile for thirty-two out of fifty-four patients, who received 200,000 to 400,000 units of penicillin daily. This observation, and many other articles, prove conclusively that prophylactic use of penicillin for such things as packed uterus, third-degree lacerations, vaginal examination before delivery, manual removal of the placenta and premature rupture of the membranes has greatly reduced the percentage of morbidity.

Kistner, in a recent article, states that for many years the management of pregnancy complicated by active pulmonary or extrapulmonary tuberculosis had been a challenging problem. The prognosis of such cases, since the advent of streptomycin, has been greatly improved. He reports five such cases with good end results.

Aureomycin will soon play an even more important role in obstetrics. Guilbeau, et al, have carried out experimental work with this drug with gratifying results. They studied a controlled group and a group treated with aureomycin during the postpartum period. The lochia was cultured in both groups. About seventy per cent of the controlled group showed positive cultures; whereas only 11.9 per cent of those treated with aureomycin showed positive cultures.

Chloromycetin and terramycin have now been added to the list of effective antibiotics at the physician's disposal. Not too much investigative work has been done with these drugs in the field of obstetrics. It has been found, however, that chloromycetin has proved beneficial in acute gonorrhea, granuloma inguinale and lymphogranuloma venereum.

Finally, some mention should be made of the other factors which have aided in reducing the fetal and maternal morbidity and mortality rates. Greenhill mentions such things as: (1) the residency training program, (2) the increased number of postgraduate courses for general practitioners, and (3) maternal welfare committees in large cities. To these I would like to add frequent departmental conferences to study the morbidity and mortality rates in the department.

Cesarean Section
(including vaginal delivery following section)

In discussing operative obstetrics we will eventually come to dwell on the advantages of cesarean sections. The techniques and indications have changed very little, but enough to promote interesting discussion. When this type of delivery was first employed it was used for a variety of conditions; with cephalopelvic disproportion, previous section, placenta praevia, and abruptio placenta comprising the greatest percentage of indications. Within recent years there has been a noticeable decrease in certain of the indications; with repeat section now leading over cephalopelvic disproportion. The other causes, although still persistent in the field, are being rapidly decreased through the use of judicious obstetrics. The most common indications for cesarean section in our experience are shown in the following tables covering the periods from 1931 to 1943 and 1943 to 1948.

Indications for Cesarean Section

1931 - 1943

Cephalo-pelvic disproportion	145
Previous section	89
Placenta praevia	49
Pre-eclampsia	28
Abruptio placenta	12
Eclampsia	4
Posthumous	3
Fibroids	1
Elderly primipara	1

1943 - 1948

Cephalo-pelvic disproportion	71
Previous section	71
Pre-eclampsia	13
Placenta praevia	12
Abruptio placenta	10
Fibroids	5
Eclampsia	3
Elderly primipara	4
Transverse lie	2

The techniques for cesarean section have been and still are as numerous as the indications. When this type of delivery was first devised, the classical section was employed and used exclusively. However, there was soon added the lower cervical cesarean section, and now the ratio of the two types is about equal. In addition to these two methods, a third

type of section was instituted for use in infected mothers to avoid entrance into the peritoneal cavity. These sections were appropriately called extraperitoneal, and the men to whom most credit can be given in this field are Latzko, Waters and Smith. Latzko developed the paravesical extraperitoneal section; while the latter two men developed the supravesical section. Both have their attributes and their disadvantages. However, the opinion now is that this type of section need no longer be employed since the advent of the almost miraculous antibiotics. One disadvantage of these types of sections is the difficulty in performing them.

More recently, the advocates of the low cervical section have come to the fore with rather convincing facts and figures. D'Esopo and his group in reviewing 1,091 cesarean sections felt that the low flap operation in conjunction with antibiotics, given before and after operation, was a safe procedure when there was potential infection. They did not condemn the extraperitoneal type section, as they admitted they had had little experience with it: a total of three cases. Mortality rates due to infection, in recent series, were so low as to be of no statistical significance. They did not agree that the so-called morbidity rate following section was a reliable method of comparing types of surgery. They felt it included more than infection and did not express the degree of infection, and furthermore, a physiological postoperative febrile response might put the case in the morbid group. They instead recorded the "Febrile Index" for all delivered cases. This they defined as the total number of tenths of degree of fever above 99 degrees of the peak daily temperatures for the first ten postpartum days exclusive of the day of delivery. Their elective cesarean sections showed the lowest febrile index. With varying periods of labor or ruptured membranes or both, the index rose, but the group which had the longest duration of labor and ruptured membranes showed a significant drop. They attributed this to the fact that these cases were most often singled out for antibacterial therapy. Nearly all of them received the drugs, and most of them were treated prophylactically. They felt that this fact indicated that this therapy had completely changed the entire aspect of the problem of infection in cesarean section. In the last half of their series, their potentially infected cases showed a febrile index which was very little above that for the entire group of elective cases. They modestly confessed little experience with actual uterine infection but felt that in these cases a cesarean hysterectomy should be done, although they had in a few cases performed low-flap operations in women with fever and foul amniotic fluid without postoperative complications.

At the same time, Gordon Douglas and Robert Landesman studied recent trends in cesarean sections and reviewed cases in particular at the New York Hospital. From 1933 to 1937, the classical type and the low-flap were used with about equal frequency. Since 1947, about three-fourths of the sections were performed by the low-flap method. They seldom used the extraperitoneal operation before 1940; thereafter the number increased to a peak in 1944. Since that year, the number has gradually fallen despite the large number of sections performed after twenty-four hours of labor. Their data clearly indicated a great increase in the use of the low-flap transperitoneal section and a reduction in the classical extraperitoneal varieties.

Prior to the advent of modern preventive surgical preparation, including prophylactic penicillin and sulfa, the low-flap section was performed usually before twelve hours of labor. In 1946 the indications for the low-flap type of operation were extended to include patients with ruptured membranes in labor for two days. Finally in 1948, the low-flap section was further extended to all patients, irrespective of the duration of labor. The extraperitoneal section was occasionally employed for teaching purposes in patients with protracted labors, although they were not impressed with the necessity for this operation. They did not feel it provided the same opportunity for controlling hemorrhage as did the low flap type. More important, they felt their data indicated that infection might be eliminated as a cause of mortality or as a serious complication when the low-flap operation was employed. They argued further that there was less danger to adjacent structures: such as, bladder, ureter and the main branches of the uterine arteries. In addition, in their experience, the postoperative course was less complicated and primary wound healing was encountered more frequently. Their only experience with a significant wound infection followed an extraperitoneal section. They, too, confessed little experience with neglected cases, but they had encountered instances where delivery through normal birth passages had to be abandoned. In these cases they had done the low-flap operation after attempted forceps, repeated vaginal examinations and other intrauterine manipulations. On several occasions the umbilical cord was maintained manually in an intrauterine position until the baby

was delivered. In these cases the puerperal course was entirely uneventful.

Another group voting in favor of the low-flap operation was the Bellevue Hospital report, which reviewed 500 sections at that institution. This included fifty-four cases with ruptured membranes for an average of thirty-nine hours and thirty-three minutes. In eighteen of these cases there was some indication of an amniotic sac infection and eight cases of grossly purulent amniotic fluid. These cases were all delivered by a low-flap section with the use of sulfonamides and/or penicillin prophylactically intra and/or postpartum. No deaths occured in this series, but the postoperative morbidity was 54.4 per cent.

Kobak, Fields and Turrow of Cook County Hospital and Mount Sinai, reporting a group of one hundred low-flap sections, felt that without the aid of sulfonamides and antibiotics the preferred procedure was a successfully performed extraperitoneal section. However, with modern chemoantibiotics, they preferred the low-flap section as the safer procedure when indications were valid. They cited the associated, and not infrequent, error of penetrating into the peritoneal cavity and the occasional unavoidable genito-urinary trauma as a hazard to a more universal usage of the extraperitoneal cesarean section and felt, if their results were substantiated in a large group of clinics, there would seldom be any need for this procedure. Their one hundred cases included fifty-three patients whom they considered to be potentially infected and forty-seven actually infected. There were no maternal mortalities. The potentially infected group had a postoperative morbidity of 33.9 per cent and the actually infected cases 57.4 per cent morbidity.

In summary, the extraperitoneal section was developed in the hope of eliminating or reducing infection as a factor in the production of maternal mortality in those women who could not be delivered vaginally. It fell into early disfavor as the mortality was almost 100 per cent. More recently, as techniques improved and better anatomical approaches were devised, the operation has gained increased popularity. It still remains a subject for controversy. Strong advocates, such as Edward Waters, feel that the safety it provides from infection outweighs all other disadvantages. Dieckmann does not think that it provides the margin of safety that a cesarean hysterectomy offers. Advocates of low cervical section argue that modern chemotherapy makes the low-flap operation reasonably safe and, therefore, more advantageous as it is a simpler procedure. Opponents of the extraperitoneal section point to the number of peritoneal contaminations and bladder injuries reported. Waters refers them to his mortality records. It is apparent that none of these men have been tremendously impressed by the statistics presented by their adversaries in this argument. The pendulum now seems to be swinging away from the extraperitoneal route, as antibiotics reduce mortality and morbidity from infection to a minimum. It is still true, however, and always will be, that there is no truly safe way to deliver a woman with an obviously infected uterus.

In justice to complete consideration of the subject of cesarean section, a short space should be devoted to the discussion of vaginal delivery following section. In referring to cesarean sections, we are immediately reminded of that old adage, "Once a cesarean, always a cesarean." We, as well as others, have sought by statistical studies and personal observations to disprove that statement, and have done so to a certain degree. In our latest report on this topic we have gathered together sixty-two patients who were delivered by way of the vaginal route after having had a previous pregnancy terminated by a section. This gave us a percentage figure of thirty-three per cent for the patients with a history of section who were successfully delivered vaginally. The incidence of ruptured uteri in this series of cases was six, or 1.5 per cent, but not in the ones subjected to a trial of labor. There was no maternal mortality or morbidity following the rupture. The fetal salvage was seventy per cent.

A trial of labor seems indicated as the management of choice in a certain number of properly evaluated patients, when supervised by a competent obstetrician in a hospital equipped to meet all emergencies. However, before a trial of labor is deemed advisable, the following conditions must be met: (1) early engagement of the presenting parts, (2) history of vaginal delivery preceding section delivery, (3) diagnosis of death or monstrosity in utero, and (4) reasonable assurance of well healed scar.

The significance of successful vaginal delivery after cesarean section is obvious. However, it is not without danger. This danger of uterine rupture occurring during labor is admitted. Furthermore, a successful vaginal delivery does not guarantee against future rupture. Fana, Casagrand and others have reported uterine ruptures occurring following

cesarean section, but with normal deliveries in the interval between. Other authors have reported vaginal deliveries following three preceding sections.

There are strenuous objections from many following such a study. The opposition maintains that fetal mortality and morbidity is increased. However, in repetition, may I remind you that none have occurred in labor. Maternal mortality is another point of objection, but statistically it is shown that neither we nor others who employ vaginal deliveries following section have increased the percentage. Thus, with somewhat little effort and judgment, may it be said that in selected cases vaginal delivery does mean less risk for both mother and child.

Newer Aspects in Treatment of Abruptio Placenta and Placenta Praevia

Showing a Reduction in Maternal and Fetal Mortality in Regards to (a) Blood Replacement, (b) Cesarean Section, and (c) Conservative Treatment

W. G. Mills states that in every discussion on the treatment of placenta previa there are two fundamental questions to be answered: namely, what to do and when to do it. The first has fortunately been simplified with the increasing safety of lower segment cesarean section, and the procedure of choice will usually be either rupture of the membranes or abdominal delivery. However, the optimum time for this intervention is now under some discussion, and expectant treatment, which was previously felt to be out of the question, is gaining some advocates. Rupture of the membranes can be performed with a great deal more confidence when it has been possible to delay until the uterus is contracting and the cervix open. In addition, the most important, by a conservative approach the fetal loss due to prematurity may be reduced.

Expectant treatment was first championed by Macfee and Johnson on both sides of the Atlantic. It was their contention that in the absence of vaginal manipulation the hemorrhage will never be fatal if the patient is carefully followed. By this treatment both of these authors found a marked lowering of fetal loss. The use of cesarean section in association with conservative treatment has varied greatly in various clinics. Subsequent reports have consistently borne out the lowering of fetal mortality by this approach to therapy, and the maternal mortality has not been increased.

Mills summarized the results obtained in one hundred cases of placenta praevia treated by six different physicians along conservative lines. No infant was to be delivered before the thirty-seventh week of gestation insofar as possible. Severe hemorrhage after the thirty-seventh week was considered cause for immediate emptying of the uterus. In those cases admitted before the thirty-seventh week with hemorrhage, they were put to bed and given sedation after the cervix had been examined by speculum. If the hemorrhage stopped, the patients were sent home for further bed rest, and if the loss was slight the patient was allowed up. In the more severe hemorrhages, all manipulation was avoided until the thirty-seventh week. At that time, vaginal examination was repeated after preparations had been made for immediate cesarean section if necessary. If the placenta was palpated up to the margin or across the cervix, section was done immediately. For the less severe types, the membranes were ruptured and frequently Willett's forceps were applied. Of the one hundred cases seen, it was possible to carry out a strictly conservative regime in only twenty-four because of the period of gestation or because of previous manipulations. In the entire group the fetal loss was sixteen per cent, and there were no maternal deaths.

Macafee, in an article entitled "Modern Views on the Management of Placenta Praevia," reports a series of 275 cases over a period of thirteen years with fifty-six stillbirths or neonatal deaths. There were two maternal deaths in this series, or 0.73 per cent. He feels that the anatomy of the placenta in placenta praevia is an important cause of intrauterine death or death of the fetus during labor. If the cord is inserted at the lower edge of the placenta in close proximity to the internal os, the first hemorrhage may cause the death of the fetus. If a velamentous insertion of the cord is present, one or more of the umbilical vessels may cross the internal os and spontaneous or accidental damage of these vessels will result in death of the fetus. In analyzing the cause of death in forty-seven babies, it was found that in thirteen cases the situation of the cord was the primary factor. Another factor over which one has no control is the incidence of fetal abnormalities.

Recent workers have advocated the use of expectant treatment in cases of placenta praevia where the hemorrhage is slight and occurs when the baby is immature. Before deciding upon expectant

treatment, each case must be considered individually, and only those cases which are suitable should be treated expectantly.

Macafee feels that to embark upon expectant treatment where the initial hemorrhage has occurred between thirty-seven to forty weeks gestation is neither justified nor safe. The case in which the expectant treatment is most valuable is the one where a small hemorrhage has occcurred at thirty to thirty-four weeks, where the baby is premature and where the baby's chance of survival is much improved if the pregnancy can be prolonged three to four weeks. The author feels that a relatively accurate diagnosis can be made from the findings on abdominal palpation. A vaginal examination should not be made until the termination of expectant treatment. X-rays should be taken of the abdomen to exclude those fetal abnormalities demonstrable by radiography and special soft tissue technique can be employed to demonstrate the position of the placenta. The author feels that active treatment should be carried out when (1) the patient has been admitted because of antepartum hemorrhage between thirty-seven weeks and full term, (2) in any patient receiving expectant treatment where the pregnancy has reached thirty-eight weeks, or (3) in the presence of more than moderate hemorrhage or where even a slight hemorrhage persists for some hours.

The group of patients in which hemorrhage has been more than moderate or has persisted presents a difficult problem. In the author's experience these cases account for the greatest number of fetal deaths. If the baby is alive and not premature, a cesarean should be performed; when it is immature or dead, a podalic version will usually control the hemorrhage. The practice of doing a lower segment in preference to the classical operation diminishes the risk of uterine rupture at a subsequent confinement.

Tiffany J. Williams states that the maternal mortality in placenta praevia has been appreciably reduced in the past decade mainly by the replacement of blood loss by adequate transfusions of whole blood. On the other hand, fetal mortality remains high, due in great measure to prematurity. In order to improve the fetal results it is necessary to carry these patients closer to term. Ample properly matched blood and caution in the use of vaginal manipulations may make it possible to continue the pregnancy until the child is larger and so increase the fetal salvage. Reports by MacAfee and Johnson have cast doubts upon the correctness of the dictum

Fetal Results With Expectant Treatment in 41 Cases; Term 32 and Premature 9

Method	Number	Term		Premature	
		Lived	Died	Lived	Died
Spontaneous	11	9	0	1	1
R Bow	15	10	0	3	2
Cesarean	15	12	1	1	1
Total	41	31	1 (3%)	5	4 (44%)

Author	No. of cases	Maternal deaths		Fetal deaths	
		No.	Cent	No.	Cent
MacAfee	174	1	0.57	41	23.0
Davis and Campbell	325	2	0.6	104	31.6
Yeppes and Eastman	111	1	0.9	52	46.8
Williamson and Greeley	162	5	3.1	50	31.1
Seeley	250	7	2.8	91	34.6
Johnson	79	0	0	26	31.0
Scott	191	5	2.6	56	29.6
Total	1,292	21	1.6	420	32.5

that there is no expectant treatment. Williams reported 105 cases of placenta praevia seen during the past eleven years; forty-one were treated in an expectant manner. He states that there can be no expectant treatment once labor has begun. Also, if the patient is at or near term, there is no advantage in attempting to prolong the pregnancy. There was one maternal death in the 105 cases, or 0.95 per cent. Twenty-nine children of the 105 patients did not survive; fourteen were stillborn and fifteen died, a neonatal-fetal mortality of 28 per cent.

Williams feels that adequate replacement of blood loss, caution in the use of vaginal manipulations with delivery either by way of section, or induction of labor by rupture of the BOW, dependent upon the station of the presenting part, the degree of praevia, and the condition of the cervix, have improved the maternal results in placenta praevia. An improvement in fetal results is dependent upon an attempt to carry these patients closer to term.

Hardy states whether the improvement in maternal and fetal salvage in recent years has been due more particularly to the increased use of the cesarean section or to greater availability and more ready use of blood replacement and to reduction of infection through chemotherapy and antibiotics is at least debatable. This author feels that the adoption of cesarean section as the standard treatment of antepartum hemorrhage has distinct disadvantages. Abdominal delivery will, in many instances, commit the woman to similar delivery in subsequent preg-

nancies. Secondly, it will lead to an increase in the number of premature infants and a consequently higher proportion of neonatal deaths. Hardy advocates selective rather than standardized treatment. In general, the best results will be obtained if the treatment is as conservative as is consonant with the safety of the mother and the interests of the child. He feels that the final decision as to cause of bleeding will rest upon information obtained by radiological visualization of the placenta or by digital examination, and that complete praevia is probably best treated in all instances by cesarean section. The same is true of most instances of incomplete praevia in primipara. However, in the multipara, in whom it is possible to find at the internal os sufficient area of uncovered membranes to permit artificial rupture, that procedure will probably be the method of choice. Hardy's maternal mortality rate was 3.2 per cent and fetal mortality rate was 25.8 per cent.

Johnson feels that if unmanipulated, the praevia patient will not bleed to death, because the blood loss is intermittent in character and occurs only when dilatation of the cervix or retraction of the lower uterine segment causes placental separation, and that this dilatation is not synchronous with each labor pain but occurs as a summation of several pains. He feels that the insistence that pregnancy be terminated as soon as placenta praevia is diagnosed is no longer defensible.

Premature separation of the normally implanted placenta occurred twenty-nine times in 9,123 deliveries or one in 365. Cesarean section was employed in fourteen cases and in none of these was it necessary to remove the uterus. There were no maternal deaths and the fetal mortality rate was 44 per cent. The milder cases were treated conservatively with rupture of the membrane and providing blood replacement when needed. Hardy feels that in the so-called utero-placental apoplexy cesarean section will offer the most favorable prognosis. He warns that the patient must first be restored to safety by transfusions and other supportive measures.

Sexton and Hertig, with the Boston Lying-In Hospital group, reported 476 cases of abruptio placenta in 40,547 deliveries; an incidence of one to eighty-five. They feel that the cesarean section should be restricted to those patients who are not in labor, in whom vaginal examination reveals a cervix which is not effaced or dilated, and in whom there is no evidence of fetal distress. They do not feel it is justifiable to submit the baby to an anticipated long labor under such circumstances with the risk of a stillbirth or neonatal death from intrauterine asphyxia. Most of the controversy in this disease has been concerned with what constitutes the proper management of patients with severe degrees of placental separation, particularly when associated with hypertension and albuminuria. These cases constitute the major portion of the maternal mortality. The treatment of severe placental separation by immediate hysterotomy followed by hysterectomy, should it be necessary to control further hemorrhage from an atonic uterus, has many advocates. This form of treatment has been predicated on the assumption that the myometrium, markedly infiltrated with blood, will not be able to function in a normal fashion during labor or following delivery. However, many patients in the nontoxic group, the majority of the moderately toxic, and all of the severely toxic group in this series were treated by the conservative method. None of these patients died from postpartum hemorrhage due to uterine atony. It would appear that if hysterotomy has a place in the treatment of this condition, it must be concerned with problems associated with labor and delivery.

In patients who enter the hospital in shock, associated with severe placental separation, blood replacement should be given immediately. Rapid investigation of the clotting ability of the blood should be done and specific replacement, that is, fibrinogen and vitamin K, should be administered. During this time artificial rupture of the BOW should be performed. At the end of two to four hours after hospital admission and following replacement therapy, if no labor has ensued and the patient has fully recovered from shock, abdominal hysterotomy then appears to be the procedure of choice.

Weiner and Reid feel that a defect in the coagulation mechanism may develop in severe premature separation of the placenta, and the blood changes are characterized by a decrease in the fibrinogen concentration and prothrombin activity and the presence of a circulating fibrinolysin. They feel that replacement therapy with fibrinogen and blood is of primary importance in the treatment of severe premature separation of the placenta.

McCain and Paliakoff treated 293 cases of premature separation of the placenta conservatively by spontaneous vaginal delivery. Operative procedures were undertaken only for obstetrical indications other than the premature separation of the placenta.

Time will not permit further review of the numerous additional factors responsible for the present safety of childbirth. You must, however, discuss them freely at your staff conferences, so that the type of obstetrics practiced in the new Bishop McAuliffe Lying-In Pavilion of St. Francis Hospital sets the example for your State.

Our beloved Samuel Cardinal Stritch, the staff of the Lewis Memorial Maternity Hospital, the teaching obstetrical hospital of the Stritch School of Medicine of Loyola University, send you, by me, their congratulations and best wishes as you go forward to further the principles of Catholic obstetrics.

REFERENCES

Adamson, Weaver, Jaimet: Can. Med. Assoc. J.; 61:6, 1949.

Beacham, et al: New Orleans Med. & Surg. J.; 101:490, 1949.

Bellevue Hospital Report: Principles & Practice of Obstetrics, DeLee & Greenhill, 8th Edition, 1943.

Casagrand, J.: Am. J. Ob. & Gynec.; 26:273, 1933.

DeLee, J. B.: Am. J. Ob. & Gynec.; 1:34, 1920.

Dieckmann, W. J.: Am. J. Ob. & Gynec.; 50:48, 1945.

D'Esopo, A. D.: Am. J. Om. & Gynec.; 50:48, 1945.

Douglas, G., and Landesman, R.: Am. J. Ob. & Gynec. 59:96, 1950.

Fava, P. V.: Am. J. Ob. & Gynec.; 32:989, 1936.

Greenhill, J. P.: Principles & Practice of Obstetrics, DeLee & Greenhill, 8th Ed., 1943.

Guilbeau, J. A., et al: Am. J. Ob. & Gynec; 58:101, 1949.

Hardy, J. A., Jr.: Ill. Med. J.; 96:367, 1949.

Hamilton, Pittami, Higgins: So. Med. J.: 42:608, 1949.

Johnson, H. W.: Am. J. Ob. & Gynec.; 59:1236, 1950.

Kamperman, G.: Am. J. Ob. & Gynec.; 60:239, 1950.

Keettel, W. C., and Plass, E. D.: J. A. M. A., 142:324, 1950.

Keettel, W. C., Scott, J. W., and Plass, E. D.: Am. J. Ob. & Gynec. 58:335, 1949.

Kistner, R. W.: Am. J. Ob. & Gynec., 60:422, 1950.

Latzko, W.: Zentrable f. Gynak. 33:275, 1909.

Mills, W. G.: Ob. & Gyne. Survey, 4:366, 1949.

MacAfee, C. H. G.: Ob. & Gyne. Survey, 5:188, 1950.

McCain, J. R., and Poliakoff, S. R.: J. A. M. A., 141:513, 1949.

Potter, E. L., and Adair, F. L.: Am. J. Ob. & Gynec., 45:1054, 1943.

Sexton, L. I., Hertig, A. T., et al: Ob. & Gyne. Survey, 5:191, 1950.

Schmitz, H. E.: Presented before the Obstetrical Society of Boston, November, 1950 (to be published).

Stone, M. L.: Am. J. Ob. & Gynec, 59:49, 1950.

Smith, E. F.: Am. J. Ob. & Gynec., 39:763, 1940. Am. J. Ob. & Gynec., 57:724, 1949.

Wammock, V. S., Carrozzino, O. M., Ingraham, N. R., and Clair, N. E.: Am. J. Ob. & Gynec., 59:806, 1950.

Waters, E. G.: Am. J. Ob. & Gynec., 39:423, 1940.

Weiner, A. E., Reid, D. E., and Roby, C. C.: Am. J. Ob. & Gynec., 60:379, 1950.

Williams, T. J.: Am. J. Ob. & Gynec., 55:169, 1949.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Blue Cross, Blue Shield and the Hospital

In 1940 about 12,000,000 people carried some form of prepayment hospital insurance and by 1952 this has reached a level of about 80,000,000 people. In 1940 about 5,000,000 people carried some form of surgical protection, while in 1952 this figure had reached approximately 60,000,000. There can be no question that this phenomenal growth of voluntary prepayment coverage has affected the hospital of today and recently Dr. Anthony J. J. Rourke, the president of the American Hospital Association* has discussed some of these effects. An important effect of such plans is seen in the public relations of the hospital; the "Blue Cross and Blue Shield membership cards constitute the greatest and most satisfactory public relations program which has ever existed in the hospital field."

Another effect has been the enhancement of the financial stability of hospitals and with this the improvement in remuneration and personnel policies for hospital workers.

There is also an important contribution seen in the health education of at least 80,000,000 people which has made earlier hospital admission possible.

A factor which Dr. Rourke properly discusses and which is of deep concern is the decrease of patients on teaching services, which, if continued, may cause the disappearance of the traditional service of this type. A marked reduction in the teaching service could have an adverse effect upon the training of medical students, interns, resident, nurses, dietitians, and all other technicians in the hospital field. Dr. Rourke suggests the possibility of prepayment health plans and medical schools agreeing to some type of program whereby certain groups may purchase hospital care for a reduced fee, and that the prepayment plan be billed for some figure less than the charges for the usual contract. This would mean that the medical school would underwrite the difference between the prepayment plan and the cost of the service.

Another problem has been created because certain benefits become available to hospitalized patients when they are not available to ambulatory patients. Dr. Rourke states, "I am confident that prepayment plans will have to more rapidly help solve the problems of covering diagnostic procedures on an outpatient basis, and that hospitals and/or doctors will have to develop greatly expanded facilities for rapid diagnostic procedures for private patients, which will be available to any doctor whether he practices in a group or alone. . . . Such facilities must be associated with a food service and bedroom service, where the patient may rest between procedures. . . . Careful study will reveal, however, that in many diagnostic problems, under our present methods, for every hour of professional consideration by the physician, twenty-three hours may be wasted in a standby system in an expensive hospital bed . . . hospitals and/or doctors must rapidly develop such facilities, and prepayment plans must add the stimulus by developing ways and means of writing coverage and furnishing finances.

Again, on the positive side, prepayment plans have brought into sharper focus the definition and separa-

*Annual Conference. Blue Cross and Blue Shield Plans, San Francisco, April 2, 1952.

tion of costs of caring for the medically indigent with the result that hospitals have a right to assume that local governments will be justly responsible for financing such care.

Dr. Rourke's evaluation of the problems and relationships associated with prepayment plans and hospital administration is a thoughtful and timely contribution to pressing needs in medical care for all of the people.

Fairfield County Activates P.R. Program

The report of the newly formed Public Relations Committee for Fairfield County, Dr. F. C. McMahon, chairman, was presented to the Fairfield County Medical Association on April 8, 1952. It shows forward thinking and important accomplishment. A recommendation that in each community an emergency panel to insure 24 hour physicians service has resulted in the activation of such programs in Bridgeport, Stamford, Greenwich, Norwalk and Danbury. A second recommendation proposes that each local society have its own public relations committee with a representative appointed to the County Committee, thus establishing a useful liaison.

An important function of local committees should be to concern itself with the matter of press releases, especially those involving patients. This would act to dispel the idea that the profession was resistant to the publication of such items.

The use of the public relations placard of the American Industrial Association designed for doctors' offices was endorsed as an excellent device for promoting mutual understanding concerning medical fees.

An important function of local public relations committee is to see that the public is informed as to the public service that doctors perform in the case of the indigent in clinics and hospitals within the area.

A final recommendation of the County Committee proposes that the County Association set up within its budget provision for the employment of an individual capable of carrying out a public relations program.

100 Years of Pharmacy

The American Pharmaceutical Association was founded in Philadelphia in October, 1852 with a membership of twenty-one. Today the membership is more than 25,000. At that time 6,139 pharmacists in the United States were registered, today 101,800 are registered. In commenting upon its centenary the Association notes many changes, among the important being activities in developing safeguards against dangers in handling drugs. One hundred years ago, retail stores that sold drugs and remedies far outnumbered apothecary shops. Today the distribution of dangerous drugs and vital medicine is limited strictly to the pharmacist and the physician. One hundred years ago but six colleges were listed by the American Council on Pharmaceutical Education, today seventy-three colleges are accredited by the Council.

The New England Health Institute

The New England Health Institute to be held at the University of Connecticut June 18-20, 1952, returns to the State of its birth in 1922. In May of that year the Health Institute came into being in Hartford, a fully developed enterprise with 850 registrants. This year, 1952, the 18th Institute is sponsored by 33 official and voluntary, health, professional and educational agencies, 24 of which belong to Connecticut. The program of over 85 topics incorporating a faculty of 120 leaders in their respective fields is directed toward broad interest important to every New England citizen. Inclusive are such topics as: medical and hospital facilities, aging, alcoholism, radio-activity, chronic diseases, rehabilitation, viruses, fluoridation, environmental hygiene, communicable disease prevention and control, occupational health, home safety, citizen responsibility, health education, civil defense, mental health, nutrition, maternal and child health, medical care programs, public health nursing, and the importance of the non professional worker in public health agencies.

Many members of the Connecticut State Medical Society are serving on the various planning committees. To them and to their associates in this significant enterprise we offer felicitations and wishes for highest success.

CMS Plan for Inhospital Medical Care

The acceptance by the House of Delegates of the inhospital medical care plan developed by Connecticut Medical Service is a significant step in the voluntary medical insurance program. That it will be inaugurated as an additional benefit without in-

crease in premium attests the alertness and interest of the management of the plan to increase insurance coverage as a public service as rapidly as is consistent with sound principles. The enrollment now reaching the half million mark is chiefly the result of the spirit of cooperation which has existed from the beginning between the Medical Society, the participating physicians, and the plan. Its phenomenal growth reflects this continued effort for mutual understanding. That the new experience will result in changes in operation is anticipated, so in the future, as in the past. The recognition of opportunities for change is fundamental in the Voluntary Way as the American Way.

Hypochondriacs' Heaven

"There's more to this than meets the eye."

The proponents of socialized medicine are usually very enthusiastic about its advantages and strangely silent about its drawbacks. The main cause of the enthusiasm is the knowldege that many people are anxious to get something for nothing. What these citizens do not realize is that such propositions always have not one but several strings attached to them, a fact that most politicians sedulously conceal, for the plan means many new political jobs. The main drawbacks of socialized medicine, even when the patient is allowed to pick the medical attendant of his choice, are threefold. Foremost is the fact that there is interposed between the patient and his physician a bureaucracy. The sick man cannot simply call in a physician as he can under existing custom; there are certain forms which must be followed, papers to be filled out, regulations which must be acceded to. Furthermore, though the patient may receive free medical care, the cost of maintaining the extensive staff of bureaucrats which runs the system will surely appear on his tax bill. Finally, his doctor, who already is somewhat entangled in red tape by the Department of Internal Revenue, may become so enmeshed in time consuming paper work that he has difficulty in finding time for the adequate care of his patients. One might add that some doctors, though we hope not many, knowing that they will surely be paid by the Government anyhow, will not give the time and attention to their patients that they do under the existing competitive system.

Every layman and doctor who is a proponent of socialized medicine, and some regular practitioners fall into this group, should carefully read the letters from British practitioners which appear from time to time in American medical journals and occasionally in popular magazines. The experience of some physicians working under socialized medicine shows that at least one-third of their office patients came, not for medical care but for various types of certificates involving paperwork which takes up so much of the doctor's time that his real job, the medical care of the sick, is seriously hampered. In Britain there are at least 200 forms that must, at one time or another, be filled in.

In these days of psychosomatic medicine, which emphasizes the importance of both physical and psychic deviations from the norm, and partly perhaps as the result of the psychic strain of hot and cold war, patients with hypochondria and other psychoneuroses have seemingly increased in number. For many years patients with preponderatingly psychoneurotic disturbances have constituted at least a third of the ordinary doctor's clientele and, the public now being neurosis conscious, will doubtless make up a much larger proportion in the future. An aspect of Socialized Medicine that has not been sufficiently considered is that if neurotics are allowed to consult physicians without restraint, they may almost swamp the practitioners and crowd out those whose ailments are preponderantly physical. Anyone with experience in handling psychoneurotics with their endless complaints and questions, their long written lists of unimportant symptoms, and their garrulity, must feel that here is a serious problem. It already has been shown by a disinterested study that there are not available in the United States enough physicians and nurses to carry out any nationwide plan of medical care. It may be added that when it comes to neuropsychiatric experts, the dearth is even greater. The question of Socialized Medicine is not one that can be settled satisfactorily by political methods, and we ardently hope that it will not be seriously considered for years to come, and that when that time comes enough evidence will have accumulated of the workability of other plans, now being tried out by the profession itself, to lead to the abandonment of Socialized Medicine in the usual sense.

G. B.

REPORT OF THE POLIOMYELITIS POLICY COMMITTEE OF THE FAIRFIELD COUNTY MEDICAL ASSOCIATION

OLIVER L. STRINGFIELD, M.D. *(Chairman), Stamford*

SINCE the last meeting of The Fairfield County Medical Association, your Poliomyelitis Policy Committee has held four meetings. The committee has been enlarged by the addition of Dr. John R. Gulash, Mr. James Dunlap, representing the Hospital Association and Miss Lillian Reiners, representing the Nurses Association. Your committee now has twelve members with Judge Cavanaugh and Mrs. Davey members ex officio. Drs. Williams, Howorth and Castaldo, with the chairman acting ex officio, are our representatives on the Executive Council of the County Chapter of the National Infantile Paralysis Foundation.

It is the concensus of this committee that polio patients can receive the best care in general hospitals. We have conferred with Dr. Hart of the State Department of Health, who states that the department has for years advocated that polio patients could best be treated in general hospitals. To date, hospital authorities have authorized the establishment of polio centers in the Greenwich Hospital, the Stamford Hospital, the Norwalk Hospital and the Bridgeport Hospital. St. Vincent's Hospital is studying the problem and will make their decision at a later date.

Your committee is studying the problem of convalescent care of poliomyelitis patients in the home, in rehabilitation centers and other means. Relative to the care of respiratory cases, it is recommended that the State Medical Society attempt, with the cooperation of the National Foundation and the State Department of Health, to set up a Respiratory Center somewhere in the State, to which would be sent all respiratory cases after the acute phase is over. We believe, in this way, better care can be given to these patients.

The nursing problem has occupied quite a bit of time of the committee. The latest report is, there will be a meeting of representative nurses from all the hospitals in the county on April 9, at which time arrangements will be made for setting up of a nurses' institute for polio. This usually lasts about five days, and will probably be given in early May. The National Foundation has authorized the expenses of several nurses to be sent to a Polio Center for intensive study. A review of the trained nurses in polio in the County show we already have quite a number of trained nurses who could be used for instructors. It is the opinion of our nurses representative on the committee that we will have an adequate number of nurses. Also, they are studying the possibility of using nurses aides and Red Cross workers in the convalescent care.

Your Policy Committee recommends that there be a local Polio Committee appointed to represent the staff of each hospital having a Polio Center. It is believed that their duties shall be to assist and work out ways and means for the proper care of these patients in their particular hospitals.

The committee has recommended that a course in the latest techniques, diagnosis, etc., in polio be studied by the physicians who are interested. We have reviewed the literature and recommend that each physician interested in the care of polio acquaint himself of the latest medical knowledge. We recommend for physician reading: Common Contagious Diseases by Philip Stimson, 1947 edition. Brenneman's Practice of Pediatrics, Volume II, Chapter 15. Poliomyelitis by James L. Wilson (1952 revision). Nursing for the Poliomyelitic Patient.

Suggested recent articles are as follows:

1. Treatment of Acute Poliomyelitis together with some suggestions on diagnosis, *Journal of Pediatrics,* Volume 31, July 1947.

2. Some of the major points in the treatment of acute poliomyelitis, *Journal of Pediatrics,* Volume 36, June 1950.

3. Treatment of Acute Poliomyelitis, *Journal of Pediatrics,* Volume 39, August 1951.

4. Acute Polio Differential Diagnosis of 409, Revised by Diagnosis, *Journal of Pediatrics,* Volume 40, January 1952.

5. The Importance of Rest in the Treatment of Further Convalescence of Polio, *A. M. A. Journal,* Diseases of Children, Volume 83, January 1952.

6. The Rapid-Rocking Bed: Its Effect on the Ventilation of Poliomyelitis Patients with Respiratory Paralysis, *The New England Journal of Medicine,* Volume 245, Number 7, August 16, 1951.

7. Arterial Hypertension Associated with Acute Anterior Poliomyelitis, *The New England Journal of Medicine,* Volume, 245, Number 7, August 16, 1951.

PROGRESS IN CLINICAL MEDICINE

INTRAMEDULLARY NAILING OF THE FEMORAL SHAFT

NED M. SHUTKIN, M.A., M.D., *New Haven*

ANATOMICAL reposition of the fragments with some unyielding means of fixation without sacrificing mobility in adjacent joints and without increasing morbidity constitutes the ultimate in the treatment of fractures. This elusive ideal is perhaps most nearly achieved in the use of the intramedullary nail in the treatment of certain fractures of the shaft of the femur. With due reservation for the extenuating circumstances that are so frequently encountered by the surgeon treating fractures, it can be said that, under certain given circumstances, intramedullary nailing of the shaft of the femur has established itself as a method of choice. Dr. Hugh Smith[9] of Memphis, the chairman of a special board of orthopedic surgeons constituted by the American Academy of Orthopedic Surgeons for the specific study of the use of the intramedullary nail in femoral shaft fractures, reviewed over 700 cases and concluded that "medullary fixation of the femur can now be accepted as a reliable, though not fool-proof, form of treatment. If applied to improperly selected cases, or inefficiently or unskilfully carried out, it offers a great array of most undesirable complications. Given the proper indications, medullary fixation has provided an excellent mechanical fixation that approaches the ideal of treatment."

The idea of achieving fixation of fractures by intramedullary rods is not a new one. However, it is only in recent years that this method has achieved popularity and success. Previous attempts were hampered by the lack of metals sufficiently inert to be tolerated by the body. Furthermore, it has been only within the past ten years or so that a rod traversing the entire length of the intramedullary canal and occupying most of its caliber has been used. In 1907, Lambotte used a long screw and later a carpenter's nail to obtain intramedullary fixation. Joly, since 1935, has used Kirschner wires for the fixation of clavicular, metacarpal, phalangeal, and malleolar fractures. Danis reported the use of the Kirschner wire for intramedullary fixation for fractures of either or both bones of the forearm and the lower one-third of the tibia. The initial reports in the United States appeared in 1937 and 1939, published by L. V. and H. L. Rush, in which intramedullary fixation of fractures of the ulna and the proximal femur by means of Steinman pins was reported. In 1949, the Doctors Rush[7] again reported their experience with intramedullary nailing, this time using a round pin extending the entire length of the medullary cavity and occupying its cross-section, the pin having a sled-runner point at one end. Küntscher, in 1940, showed convincingly that intramedullary fixation could be used. For the first time he used a metal rod that occupied the full length of the medullary canal and large enough to allow introduction with a snug fit in the cross-section. Küntscher employed blind nailing without exposing the fracture site. The rod was subsequently extracted several months or more later after satisfactory x-ray evidence of definite consolidation of the healing callus. This technique was discovered in England, France, and the United States through the medium of the technique being employed on various Allied prisoners of war. The technique fostered by Küntscher gained popularity despite early theoretical criticism. Favorable reports by other European authors followed. Habler and Böhler in Germany, Soeur in Belgium, Mondor and Nardi in France, Westerborn in Sweden, all reported favorably on this technique. Intramedullary nailing rapidly gained favor in America. However, a certain amount of the difficulty and morbidity in doing this procedure was derived from the closed method of introduction of the nail. This closed method has been almost universally discarded in favor of the open retrograde technique of nailing.

An enumeration of the advantages of intramedullary nailing can be considered the pillars of sound fracture treatment: (1) accurate reduction, (2) solid and dependable fixation without diastasis or maintaining distraction of the fragments, as with other forms of internal fixation, (3) allowance for function of muscles and joints in the involved extremity

during the healing process, (4) a short period of hospitalization and disability with the obvious psychological and economic advantages. On the other hand there are certain limitations, disadvantages, and undesirable effects attendant to intramedullary nailing which must be taken into consideration. Some of these are of very definite clinical significance whereas others are merely academic in nature and have been shown by clinical experience to be of little or no practical import. Intramedullary nailing is a major surgical procedure with all the various possibilities of morbidity and mortality attendant to major surgery. Shock, particularly in the event of the necessity of forceful hammering, is always a threat. The hazard of infection, inasmuch as this retrograde technique entails the conversion of a simple fracture into a compound fracture, must be taken into consideration. Another major objection is the delay in callus formation that seems to occur frequently. Böhler[1] felt that the endosteal callus was inhibited by the pressure of the intramedullary nail occupying snugly the cross section of the medullary cavity. He also felt that there was a definite inhibition of union across the opposing cortical margins of the fracture site. This has been a controversial point among various authors, with the evidence favoring those who claim an inhibition of callus formation. However, this does not constitute a major objection inasmuch as the intramedullary nail maintains sturdy fixation for as long a period as necessary and the nail need not be removed until there is indisputable x-ray evidence of consolidation of the healing bone at the fracture site. A major academic objection to the technique of intramedullary nailing was the possibility of its promoting morbidity or mortality from fat embolism. Clinical experience has shown that this objection has no validity. Sputum studies have shown that more patients with fractures of the shaft of the femur treated by other means have fat in their sputum than do patients who have been subjected to intramedullary nailing. In fact, a recent paper by Whitson[14] casts considerable doubt upon the validity of our current concepts of fat embolism. Other academic objections such as bone marrow destruction or interference with hemopoesis have been shown to be without any foundation.

The current technique employed is that of open, retrograde insertion of the nail.[2] In general, the fracture site is exposed and a nail of proper length and cross section is inserted in a cephalad direction, into the medullary canal of the proximal fragment. When necessary, the canal is reamed out first. Progressive insertion of the nail causes it to break through the cortex of the trochanter and present itself in the soft tissues above the trochanter. The nail is then delivered through a stab wound in the trochanteric region until the lower end of the nail is flush with the distal end of the proximal fragment. The fracture is then reduced, and the nail driven downward, thus engaging the distal fragment.

At present, there are three types of nail commonly used for femoral shaft fractures: the diamond-shaped Hansen-Street nail; the clover-leaf Küntscher nail; and the circular nail with the sled-runner point of Rush.

In order to avoid some of the common occurrences of morbidity and complications attendant to intramedullary nailing, certain technical considerations must be rigidly adhered to. The procedure should be employed only in adults. The use of the intramedullary nail in children entails the danger of injury to an epiphyseal cartilage with the possibility of subsequent interference with growth and of deformity. The procedure is used in all simple fractures of the shaft of the femur providing comminution is not too great. According to Street, the smaller major fragment must be at least 10 cm. in length in order for the nail to achieve sufficient purchase within the medullary canal to provide satisfactory stability. In the event that mild comminution is present, the intramedullary nail can be used with further local fixation of the comminuted fragments by other means of internal fixation. The intramedullary nail has also been used in certain compound fractures where the wound of compounding has not been very great, where the amount of soft tissue destruction has been minimal, and where the procedure was deferred for from two to three weeks during which time antibiotic therapy was employed. The procedure can also be used in cases of pseudarthrosis, malunion, nonunion, in femoral shortening procedures, and in pathological fractures. Satisfactory results have been reported in pathological fractures resulting from Paget's disease, metastatic carcinoma, osteitis fibrosa cystica, and multiple myeloma.

One of the most important technical considerations is the proper selection of the intramedullary nail, both in regard to its length and to its cross section. The proper length can be ascertained in some cases by x-rays of the uninvolved femur with

an intramedullary nail of a known size strapped to the thigh. Various other measuring devices and orthoroentgenographic techniques have also been devised. Exposure of the medullary canal provides the surgeon with the opportunity to test the nail of selected length for the proper cross section. Reamers of specific size insure proper caliber of the medullary canal. A snug fit it desirable, but care must be exercised to avoid the most embarrassing complication of incarceration of a partially introduced nail in the medullary cavity. Such cases have been reported, in which the surgeon was unable to introduce completely or to remove the partially introduced nail and was obliged to discontinue the operation and defer its completion for several days during which time pressure necrosis allowed the nail to loosen. Other complications of this misfortune is the development of surgical shock from the excessive pounding, or splitting of the femoral shaft that obliges the surgeon to abandon the procedure. Conversely the nail must not be too short or of insufficient caliber, or inadequate fixation will result.

A femur that is bowed with a comparable curve in the medullary canal also is not amenable to intramedullary fixation. Cases have been reported of penetration of the cortex by the nail with injury to the popliteal artery and to the sciatic nerve. Otherwise the procedure can be routinely performed, provided no sepsis is present and provided the patient's general condition is such which warrants any major surgical procedure.

The majority of the complications and errors in technique stem not so much from the complexity of the procedure but rather from the lack of awareness of certain pitfalls, attributable to the inexperience of the surgeon. The majority of complications and errors in technique are ones that are avoided when the surgeon becomes sufficiently conversant with the details of the procedure, pre- and postoperative as well as operative. Key and Lottes[9] reviewed the complications noted in 680 cases of intramedullary nailing of the femur, and found 230 instances of complication of sufficient importance to be clinically significant. This constitutes an incident of 35 per cent. These 230 instances of complication represented thirty-two different types. The more important are enumerated: shock, improper length or width of the nail; cutting out of nail; additional comminution or splitting of femoral shaft; incarceration of the incompletely introduced nail; formation of an adventitious bursa about the protruding upper end of the nail; breaking of the guide pin; failure to obtain adequate reduction in which the axial alignment of the fragments is satisfactory but in which there is rotational deformity of the distal fragment; angulation at the fracture site with or without angulation of the nail due to excessive weight bearing before adequate healing occurred or in fracture in which one of the fragments was too short; breakage or bending of the nail several months postoperative; malunion of the fracture from too early removal of the nail; distraction of the fragments to an extent sufficient to delay union in some cases where traction was used for too long a period postoperatively; delayed union in which the callus had not adequately consolidated to warrant removal of the nail one year or more after insertion; thrombophlebitis; and infection.

Infection occurred not infrequently, but fortunately did not entail any severe or prolonged morbidity. Hart reviewed 800 cases of intramedullary nailing of all bones and found the incidence of postoperative infection to be 11 per cent. However, virtually all of the cases reported in which postoperative infection occurred responded to adequate drainage of the fracture site and chemotherapy, and in no cases obliged the surgeon to remove the intramedullary nail prematurely. In fact, it is the opinion of several authors that the presence of the intramedullary nail not only does not contribute to medullary dissemination of the infection, but actually acts to promote drainage, thereby enhancing overcoming the infection.

The following is a very cursory summary of current reports in the literature of series of cases of various types in which intramedullary nailing was done. Westerborn[13] reported 69 cases of recent fracture of the femoral shaft and 24 cases of pseudarthrosis for various reasons in which union occurred in all instances. Ehrenhoft and Tidrich[4] reported the successful use of intramedullary nailing in pathological fractures secondary to Paget's disease (4 cases), metastatic carcinoma (5 cases), and one case of multiple myeloma. The authors reported that all cases of pathological fracture secondary to Paget's disease were solidly healed in four months. Böhler and Böhler[1] reported 700 cases of long bone fractures, the majority of which were fractures of the shaft of the femur, in which union occured in all cases. They also reported the successful use of intramedullary nailing in four cases of

osteitis fibrosa cystica. D'Aubigne[3] reported 126 cases of nonunion of the femur successfully treated with intramedullary nailing. Hugh Smith[8] reported 398 cases of various types in which the procedure was successfully used. Street[11] reported 100 cases, 90 of which had been followed for six months or more. Of these 90, 88 had healed solidly and two were apparently healing without any complications. Among these 90 cases were 17 cases of old fracture of the shaft of the femur unsuccessfully treated by other means including skeletal traction, open reduction with a slotted plate, open reduction with dual plates, onlay bone graft, plate with bone graft, medullary bone peg, and multiple fixation screws. Prompt union occurred in all following intramedullary nailing.

BIBLIOGRAPHY

1. Böhler, L., and Böhler, J.: Küntscher's Intramedullary Nailing. J. Bone and Joint Surg., 31 A: 295, April 1949.

2. Campbell's Operative Orthopedics, J. S. Speed and H. Smith, 2d Ed., C. V. Mosby and Company, St. Louis, 1949.

3. D'Aubigné, R. M.: Surgical Treatment of Non-union of Long Bones. J. Bone and Joint Surg., 31 A: 256, 1949.

4. Ehrenhoft, J. L., and Tidrich, R. T.: Intramedullary Bone Fixation in Pathological Fractures. S. G. O., 88:519, April 1949.

5. Hoebler, C.: Experiences with Marrow Nailing Operations According to the Principles of Küntscher, U. S. Naval M. Bull., 49:1033, November-December, 1949.

6. MacAusland, W. R.: Medullary Nailing of Fractures of Long Bones. S. G. O., 84:8589, January 1947.

7. Rush, L. V., and Rush, H. L.: Evolution of Medullary Fixation of Fractures by a Longitudinal Pin. Am. J. Surg., 78:324, September 1949.

8. Smith, H.: Intramedullary Fixation. J. Bone and Joint Surg., 32 A: 464, 1950.

9. Smith, H.; Luck, J. V.; Hampton, O., Jr.; Sofield, H. H.; Davis, J. B.; Spittler, A. W.; Fowler, B.; Soto-Hall, R.; Nickel, V. L.; Thomson, J. E. M.; Key, J. A.; Lottes, J. O.; Thompson, M. S.; Alldredge, R. H.; Morris, H.; Cave, E. F.; McLaughlin, H. L.; Street, D. M.; Funk, F. J., Jr.; Symposium: "Medullary Fixation of the Femur," Instructional Course Lectures, Am. Asso. Orth. Surg., Vol. VIII, J. W. Edwards, Ann Arbor, 1951.

10. Soeur, R.: Intramedullary Pinning of Diaphyseal Fractures. J. Bone and Joint Surg., 28-309, 1946.

11. Street, D. M.: One Hundred Fractures of the Femur Treated by Means of the Diamond-shaped Medullary Nail. J. Bone and Joint Surg., 33 A:659, July 1951.

12. Watson-Jones, R.; Bonnin, J. G.; King, T.; Palmer, J.; Smith, H.; Vaughan-Jackson, O. J.; Adams, J. C.; Burrows, H. J.; Nicoll, E. A.; vom Saal, F.; Trevor, D.; LeVay, A. D.; Medullary Nailing after Fifty Years. J. Bone and Joint Surg., 32 B:694, 1950.

13. Westerborn, A: Marrow Nailing in Recent Fractures, Pseudarthroses and Bone Plastic Operations. Ann. Surg., 127:577, April 1948.

14. Whitson, R. O.: A Critique of Fat Embolism. J. Bone and Joint Surg., 33 A: 447, April 1951.

Research Cardiac Grants

The second allocation of funds for research projects was recently made by the Research Committee of the Connecticut Heart Association when four grants totaling $2,650 were approved. Nearly $13,000 has been allocated for research work in Connecticut since the Committee was formed last year. Four other requests for funds could not be granted at this time since the money was not available. It is hoped that local chapters will undertake the support of these projects.

Association of Connecticut Tumor Clinics

Notice of election of officers: Dr. Tibor deCholnoky, chairman; Dr. Robert Tennant, secretary.

Executive Committee: Dr. Vincent J. Vinci, Middletown; Dr. Louis P. Hastings, Hartford; Dr. Joseph C. Woodward, New London.

Connecticut Represented in Elections to National Academy

At the annual meeting of National Academy of Sciences, Dr. Loeb was elected to membership on Academy Council, along with Wendell M. Stanley, chairman of biochemistry department at University of California. Elected to Academy membership were following, among others: Dr. Fuller Albright, associate professor of medicine, Harvard; Dr. Philip Duryee McMaster and Dr. Dilworth Wayne Woolley, both of Rockefeller Institute for Medical Research, and Dr. Joseph Stewart Fruton, professor of biochemistry at Yale.

Jailed for Selling Barbiturates

Food and Drug Administration reports a 6 months jail sentence meted out to a Seattle druggist who sold barbiturates without prescriptions, also a 7 day sentence for an Arizonan who shipped an unlabeled sex hormone (cost: $1.75) to a California customer to "increase sexual virility" (price: $60).

THE PRESIDENT'S PAGE

Connecticut Medical Service, a prepayment surgical insurance plan is now in its third year with 500,000 subscribers. Ninety-six percent of the doctors of the State who perform the type of surgery covered by this plan are participating physicians. Connecticut Medical Service, a voluntary prepayment insurance project, is well named The Doctors Plan. This plan owes its existence to the cooperation of the doctors in accepting reduced fees thus providing the best possible surgical care to those families in the lower income groups. It is recognized by all that the cost of surgical care is beyond the means of many families under present economic conditions.

The basic principle of insurance is to distribute the loss. Each beneficiary of Connecticut Medical Service bears part of the expense of the surgical care of his neighbor. The participating physician in accepting a reduced fee for his surgical service bears a major part of the burden of this distributed loss. What a wholesome feeling of satisfaction must be experienced by those participating physicians who have the privilege of contributing to a plan that has made available to so many families the best of surgery at a cost that is within their financial means!

There are now, in this country, 23 million people who are protected under voluntary insurance plans against medical and surgical expenses similar to Connecticut Medical Service. With the expansion of these insurance plans and the continued supervision of their administration by physicians, the country will be saved from the folly of nationalized medicine.

The Connecticut State Medical Society is happy to record its approval and commendation of the unselfish efforts that have been made by those members of the Society who with zeal and enthusiasm have in three years brought Connecticut Medical Service to one quarter of the population of the state, an enrollment second only to Massachusetts and Michigan in percentage of population.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

OFFICERS AND COMMITTEES 1952 - 1953

Officers and Committees to be Elected by the House of Delegates

President-Elect	George H. Gildersleeve, Norwich
First Vice-President	Thacher W. Worthen, Hartford
Second Vice-President	Carl C. Harvey, Middletown
Treasurer	Frank H. Couch, Cromwell
Executive Secretary	Creighton Barker, New Haven
Editor of JOURNAL	Stanley B. Weld, Hartford
Literary Editor of JOURNAL	Herbert Thoms, New Haven

TWO DELEGATES AND TWO ALTERNATES TO THE AMERICAN MEDICAL ASSOCIATION—for the term January 1, 1953 to December 31, 1954

Joseph H. Howard, Bridgeport
Alternate: Oliver L. Stringfield, Stamford
Stanley B. Weld, Hartford
Alternate: Benjamin V. White, Hartford

SPEAKER OF THE HOUSE OF DELEGATES

Cole B. Gibson, Meriden

VICE-SPEAKER

Thomas M. Feeney, Hartford

COMMITTEE ON POSTGRADUATE EDUCATION—to appoint the entire committee and name chairman. (Not less than seven members.)

James W. Colbert, New Haven, *Chairman*
Bliss B. Clark, New Britain
Allen F. Delevett, Bridgeport
Hugh L. Dwyer, New Haven
Malcolm M. Ellison, New London
William J. Lahey, Hartford
Robert M. Lowman, New Haven
Benjamin E. Lyons, Norwalk
A. Rocke Robertson, Torrington
Charles Russman, Middletown
C. N. H. Long, New Haven, Associate Member

COMMITTEE ON HONORARY MEMBERS AND DEGREES—shall consist of three latest past presidents, one member for a term of three years to succeed Samuel C. Harvey

Charles H. Sprague, Bridgeport, *Chairman*
Thomas J. Danaher, Torrington
Brae Rafferty, Willimantic

EDITORIAL BOARD OF THE JOURNAL—to nominate entire committee, five members, and appoint chairman

Stanley B. Weld, Hartford, *Chairman*
Frank Jones, Hartford
Marshall C. Pease, Ridgefield
Clair Rankin, Hartford
Herbert Thoms, New Haven
Harold S. Burr, New Haven, Associate Member

COMMITTEE ON HOSPITALS—to nominate entire committee, not less than six members and appoint chairman

William M. Shepard, Putnam, *Chairman*
Arthur J. Adams, Torrington
Willard E. Buckley, Middletown
Nathan H. Friedman, Stratford
Arthur A. Johnson, Waterbury
Maxwell O. Phelps, Hartford

COMMITTEE ON INDUSTRIAL HEALTH—to nominate the entire committee, not less then ten members, and appoint chairman

Preston N. Barton, Bristol, *Chairman*
Harold A. Bergendahl, Norwich
J. Edward Canby, West Hartford
George H. Carter, Willimantic
Harold M. Clarke, New Britain
Bernard S. Dignam, Thompsonville
Harry S. Frank, Middletown
John N. Gallivan, East Hartford
Richard J. Hinchey, Waterbury
Andrew J. Jackson, Waterbury
John F. Kilgus, Litchfield
Robert P. Knapp, Manchester
Daniel F. Levy, New Haven
Milton F. Little, Hartford
J. Wister Meigs, New Haven
Philip J. Moorad, New Britain
Frank T. Oberg, Bridgeport
Andrew W. Orlowski, Torrington
Israel S. Otis, Meriden
Crit Pharris, Glastonbury
Harold P. Stetson, Southington
Arthur A. Tower, Meriden
Paul W. Vestal, New Haven
Ellwood C. Weise, Bridgeport
Harold W. Wellington, New London
J. Alfred Wilson, Meriden
C. Frederick Yeager, Bridgeport

Committee on Medical Education and Licensure—a nomination to the Connecticut Medical Examining Board, one member for a period of five years to succeed Louis P. Hastings, commencing January 1, 1953

Louis P. Hastings, Hartford

Committee on State Legislation—Appoint chairman. Members nominated by the county associations

Clifford D. Moore, Stamford, *Chairman*, Fairfield County

Committee on Public Health—To nominate the entire committee and appoint chairman. This committee is limited to 15 and must have a representative from each county

J. Harold Root, Waterbury, *Chairman*
Clement F. Batelli, New Haven
John W. Buckley, Bridgeport
Henry Bunting, New Haven
Alfred L. Burgdorf, Hartford
William M. Edmonstone, Mystic
Gilbert R. Hubert, Torrington
Robert R. Kenney, Jr., Manchester
Charles A. Murphy, Stamford
Luther K. Musselman, New Haven.
Mario L. Palmieri, Middletown
Charles N. Sullivan, New Britain
R. Bruce Thayer, Hazardville
William A. Wilson, Hartford
John A. Woodworth, Moosup
F. Lee Mickle, Hartford, Associate Member

Committee on Mental Health—To nominate entire committee, not more than eight members, and appoint chairman

Franklin S. DuBois, New Canaan, *Chairman*
Francis J. Braceland, Hartford
John H. Bumstead, New Haven
Charles W. Culotta, New Haven
John H. Foster, Waterbury
Foster E. Priddy, Hartford
G. Gardner Russell, Hartford

Cancer Coordinating Committee—To nominate entire committee and appoint chairman. This committee shall be not less than seven nor more than nine members and at all times include the President of the Connecticut Cancer Society, Chairman of the Association of Tumor Clinics, and a representative of the State Health Department

Allan J. Ryan, Meriden, *Chairman*
Matthew H. Griswold, Hartford
Ralph E. Kendall, Hartford
William Mendelsohn, New Haven
Edward J. Ottenheimer, Willimantic
Benjamin R. Reiter, Bridgeport
Francis A. Sutherland, Torrington
President Connecticut Cancer Society
President Association Tumor Clinics.

Program Committee—One member for a term of three years to succeed John C. Leonard. Samuel D. Kushlan, so that the Committee will consist of:

Stevens J. Martin, Hartford, *Chairman*
John F. Nolan, Bridgeport
Samuel D. Kushlan, New Haven

Committee on Public Relations—To nominate entire committee, to consist of eight members, and appoint chairman

William G. H. Dobbs, Torrington, *Chairman*
David Bates, Putnam
Harold A. Bergendahl, Norwich
Burdette J. Buck, Hartford
Gaert S. Gudernatch, Sharon
Morris Hankin, New Haven
Charles E. Jacobson, Jr., Hartford
Harry C. Knight, Middletown
Frank C. McMahon, Stamford

Delegates to State Societies and Special Societies—For a term of one year July 1, 1952 to June 30, 1953

To Maine:

James D. Corridon, South Norwalk
Stanley B. Weld, Hartford

To Massachusetts:

John C. Leonard, Hartford
Edgar C. Yerbury, Middletown

To New Hampshire:

George H. Gildersleeve, Norwich
Berkley M. Parmelee, Bridgeport

To New Jersey:

Katherine S. Quinn, Bridgeport
Oliver L. Stringfield, Stamford

To New York:

Brae Rafferty, Willimantic
Edward J. Whalen, Hartford

To Rhode Island:

William J. H. Fischer, Milford
Moses Margolick, Putnam

To Vermont:

Carl C. Chase, Middletown
Charles T. Schechtman, New Britain

Special Societies

To Connecticut Hospital Association
William M. Shepard, Putnam

To Connecticut Pharmaceutical Association
Barnett Greenhouse, New Haven

To Connecticut State Dental Association
President of the Society

To Connecticut Nurses' Association
President-Elect of the Society

Committees Appointed by the Council Without Election by the House of Delegates

Committee on Cooperation with the Yale School of Medicine

Walter I. Russell, New Haven, *Chairman*
Howard S. Colwell, New Haven
Daniel Hardenbergh, Bridgeport
F. Erwin Tracy, Middletown
N. William Wawro, Hartford
Benjamin V. White, Hartford

Conference Committee with Connecticut Pharmaceutical Association

Barnett Greenhouse, New Haven, *Chairman*
Martin I. Hall, Bristol
Benjamin Katzin, Torrington
Fritz M. Meyer, Bridgeport
Allan K. Poole, New Haven
Louis Soreff, East Hampton
William V. Wener, Norwich

Advisory Committee to Woman's Auxiliary

Harry C. Knight, Middletown, *Chairman*
Edwin R. Connors, Bridgeport
Thomas M. Feeney, Hartford
Barnett P. Freedman, New Haven
Winfield O. Kelley, Norwich
Kenneth K. Kinney, Willimantic
Hyman A. Levin, New Haven
Frank L. Polito, Torrington

Committee on National Legislation

D. Olan Meeker, Riverside, *Chairman*
Frank H. Couch, Cromwell
Henry Merriman, Waterbury
Charles T. Schechtman, New Britain
Edward P. White, Hartford
Chairman, Committee on State Legislation
Executive Secretary

Committee on State Blood Bank

Ralph E. Kendall, Hartford, *Chairman*
Irving B. Akerson, Bridgeport
Gerald J. Carroll, Norwich
Joseph O. Collins, Waterbury
Frederick Hartman, New London
Louis P. Hastings, Hartford
Christie E. McLeod, Middletown
Lincoln Opper, Torrington
Karl T. Phillips, Putnam
J. Geoffrey Snavely, Stamford
Levin Waters, New Haven
Donald B. Wells, Hartford
Ira V. Hiscock, New Haven, Associate Member

Committee on Medical Care of Veterans

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
George A. Buckhout, Bridgeport
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven
Benjamin M. Shenker, Middletown

Committee on Rural Medical Service

Norman H. Gardner, East Hampton, *Chairman*
Frederick A. Beardsley, Willimantic
Gaert S. Gudernatch, Sharon
Enos J. O'Connell, Unionville
William H. Pomeroy, Poquonnock
William H. Upson, Suffield

Advisory Committee to the State Board of Examiners for Nursing

Creighton Barker, New Haven
Joseph A. Fiorito, New Haven
Archibald W. Thomson, Middletown

Representatives to the New England Postgraduate Assembly

Hugh L. Dwyer, New Haven
Stanley B. Weld, Hartford

Delegates to the Council of New England State Medical Societies

Cole B. Gibson, Meriden
William H. Horton, Windsor
Joseph H. Howard, Bridgeport

Committee on Chronically Ill

George A. Wulp, Hartford, *Chairman*
Richard I. Barstow, Norfolk
Sidney Drobnes, Norwich
Martin Heinemann, New Haven
James S. Missett, Hartford
Michael S. Shea, New Haven
Harold E. Speight, Middletown
Alexander J. Tutles, Bridgeport

Committee to Study Maternal Mortality and Morbidity

Carl E. Johnson, New Haven, *Chairman*
Eric H. Blank, New London
Joseph H. Howard, Bridgeport
Norman C. Margolius, Waterbury
Hugh K. Miller, Stamford
Charles H. Peckham, Manchester
A. Rocke Robertson, Torrington
W. Leslie Smith, Hartford
Hoyt C. Taylor, Meriden
Stanley B. Weld, Hartford
Elizabeth C. Wells, Hartford

Advisory Committee to the Public Welfare Department

Alexander B. Tutles, Bridgeport, *Chairman*
Payson B. Ayres, Cos Cob
Creighton Barker, New Haven
Wilbur H. Caney, Watertown
Ettore F. Carniglia, Hartford
Sidney Drobnes, Norwich
Theodore S. Evans, New Haven
F. Erwin Tracy, Middletown

Delegate to Connecticut Nutrition Council

Max Caplan, Meriden

Representative—Connecticut Committee, Food, Drugs, Cosmetics and Devices

Hugh L. Dwyer, New Haven

Committee on Student Members

Morris P. Pitock, Bridgeport, *Chairman*
William F. Bauer, Jr., Middletown
William E. Bloomer, New Haven
William H. Lohman, East Hartford
James D. McGaughey, III, Wallingford
Allan K. Poole, New Haven
Arthur C. Unsworth, Hartford
John B. Wells, Hartford
Executive Secretary of the Society

Medical Advisory Committee to the Veterans Placement Board

Bliss B. Clark, New Britain, Surgeon
Russell V. Fuldner, New Haven, Orthopedist
Robert V. Nespor, Westport, Internist
Charles I. Solomon, Hartford, Psychiatrist
Arthur C. Unsworth, Hartford, Ophthalmologist

Conference Committee for the Improvement of the Care of the Patient

Herbert D. Lewis, New Haven
Katherine S. Quinn, Bridgeport
D. Dillon Reidy, Hartford
Representatives from Connecticut State Nurses' Association
Representatives from Connecticut Hospital Association

Conference Committee with Connecticut State Dental Association

Edward T. Wakeman, New Haven, *Chairman*
Philip S. Brezina, Bristol
Cornelius S. Conklin, Bridgeport
Camille H. Huvelle, Torrington
Arnaud R. LaPierre, Norwich

Committee on Building Management

Cole B. Gibson, Meriden, *Chairman*
Stanley B. Weld, Hartford
President of the Society

Committee on Emergency Medical Service

William B. Smith, Hartford, *Chairman*
Orpheus J. Bizzozero, Waterbury
Alfred L. Burgdorf, Hartford
Joseph J. Esposito, Bridgeport
Ralph W. Kendall, Hartford
Benjamin B. Whitcomb, Hartford
C. Frederick Yeager, Bridgeport
Representative from State Department of Health
Representative from Connecticut State Nurses' Association
Representative from Connecticut Hospital Association
Representative from Connecticut State Dental Association
Representative from Connecticut Pharmaceutical Association

Advisory Committee to the State Health Department on Psychiatric Clinics

James C. Fox, Jr., Hartford, *Chairman*
Wilmar M. Allen, Hartford
Harold A. Bancroft, Hartford
Arthur Jackson, Washington
Alfred Labensky, New London
Harry L. F. Locke, Hartford
Allan K. Poole, New Haven
William B. Terhune, New Canaan
Mr. William J. Donnelly, Greenwich Hospital, Greenwich
Mr. Richard Hancock, Lawrence and Memorial Hospital, New London

Medical Advisory Committee to the State Department of Education

Orville F. Rogers, New Haven, *Chairman*
Elisabeth C. Adams, Guilford
Ralph L. Gilman, Storrs
Benjamin Wiesel, Hartford
Charles C. Wilson, New Haven

Meetings Held in May

May 5—1952 Clinical Congress Committee

May 6—Governor's Commission to Study Medical and Allied Education

May 8—Council

May 9—Program Committee Connecticut Heart Association

May 12—Committee on Cooperation with Yale School of Medicine
Cancer Coordinating Committee

May 14—Committee on Maternal Mortality
Committee on Rural Health

May 15—Connecticut Medical Service

MEETINGS HELD IN MAY *(Concluded)*

May 26—Advisory Committee to Yale Institute on Industrial Health

May 28—Governor's Special Committee on Mental Health

New Members — April 1952

TOLLAND COUNTY

Marjorie A. Purnell, Rockville

MIDDLESEX COUNTY

Victor W. Higgins, Essex
Horace J. Prescod, Middletown

Student Members

Frederick A. Klipstein, Greenwich
Columbia University, College of Physicians & Surgeons—Class of 1954
Pre-Med: Williams College
Parent: August Klipstein

Edward A. Krull, Oakville
Yale School of Medicine—Class of 1955
Pre-Med: Yale
Parent: Alexander Krull

Raymond L. Standard, Hartford
Howard University—Class of 1952
Pre-Med: Howard
Parent: Vivian L. Standard

John S. Wilson, West Hartford
Columbia University, College of Physicians & Surgeons—Class of 1955
Pre-Med: Trinity College
Parent: Dr. William A. Wilson

Fifty Year Pins Presented

At the annual dinner of the State Medical Society in Hartford on April 30 four physicians were presented with pins indicating 50 years of active membership in the Society. The presentations were made by Brae Rafferty, retiring president, to Millard F. Allen of New Haven (in absentia), William T. Bronson of Danbury, Patrick J. Dwyer of Waterbury, and Charles O. Purinton of New Hartford (in absentia).

Hartford Has New Governor



JOHN C. LEONARD, M.D.

John C. Leonard, director of medical education at the Hartford Hospital, has been selected by the American College of Physicians as the physician to be Governor of the College from Connecticut. Dr. Leonard's term of office is three years. The next annual session of the College will be held at Atlantic City, April 13-17, 1953. The Board of Governors meets during this session.

Two Stamford Interns Named for Residencies in General Practice

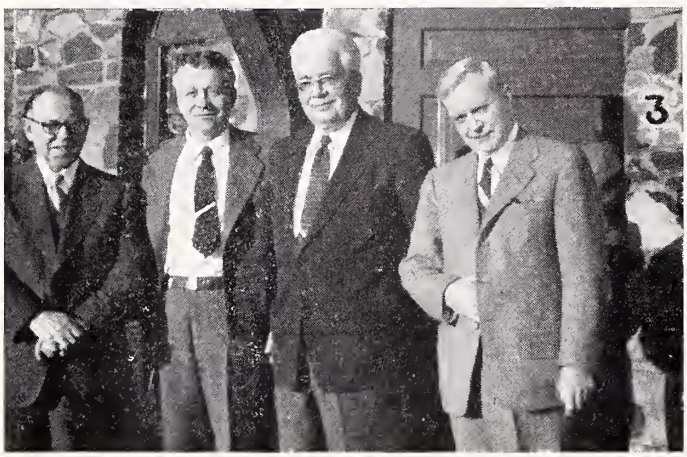
Winner of one-year residency training scholarships offered by the American Academy of General Practice were announced at Atlantic City, N. J. at the opening session of the Academy's annual Scientific Assembly in March.

The five interns named for 1952 will each receive a $1,000 scholarship from a fund created by Mead Johnson and Co., manufacturers of nutritional products. James Thomas Riley of Burlington, Vt., an intern at Stamford Hospital, is among the 1952 honorees. Harley Grupe Shepard of Stamford Hospital was selected as an alternate for the 1952 awards.

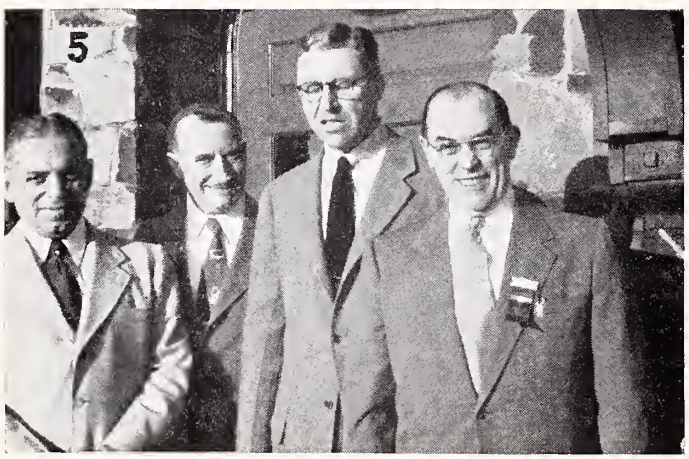
Snapped at the Annual Meeting













SEEN AT THE ANNUAL MEETING

1. Karl T. Phillips, Putnam; Thomas M. Feeney, Hartford; William A. Rice, Springfield, Mass. (Delegate)
2. Curtiss G. Tripp, New Bedford (Delegate); James Cullen, Hartford
3. Arthur Woodman, Springfield, Vt. (Delegate); James Burch, New Haven; W. Bradford Walker, Cornwall, Edward J. Whalen, Hartford
4. James R. Miller, Hartford; Frank H. Couch, Cornwall
5. Stevens J. Martin, Hartford; John C. Leonard, Hartford; Brae Rafferty, Willimantic; Thomas Martin, Portland, Maine (Delegate)
6. Stanley B. Weld, Hartford; James D. Gold, Bridgeport

From the Art Exhibit









AMONG THE PRIZE WINNERS

CONNECTICUT PHYSICIANS ART ASSOCIATION — 1952 EXHIBIT

1. Pool's Edge, H. Saxton Burr, New Haven, 1st Landscape Prize
2. Portrait of a Young Rabbi, Walter Grossman, Hartford, 1st Portrait Prize
3. Chrysanthemums, Mrs. Wilson Powell, Hamden, 1st Still Life Prize
4. A Corner in the Sculpture Exhibit

Prize Winners

Best in Show—Dr. W. W. Wright, 200 Fern Street, West Hartford. Honorable Mention: Mrs. Bernard Brody, Hilltop Road, Hamden.

Landscape—Dr. H. Saxton Burr, 37 Loomis Place, New Haven. Honorable Mention: Dr. H. E. Allen, 30 Prospect Street, Waterbury.

Portrait—Dr. Walter Grossman, 34 Canterbury Street, Hartford. Honorable Mention: Mrs. David Waskowitz, 33 Wightman Road, New Britain.

Still Life—Mrs. Wilson Powell, 210 Santa Fe Avenue, Hamden. Honorable Mention: Mrs. John Churchill, 195 Wood Pond Road, West Hartford.

Water Color—Mrs. Edward H. Crosby, 252 Edgewood Street, Hartford. Honorable Mention: Mrs. Nicholas A. Marinaro, Cedarcrest Sanatorium, Newington.

Ceramics—Mrs. Samuel Climo, 25 Woodside Terrace, New Haven.

Sculpture—Mrs. Gerald Greene, 151 Maplewood Avenue, West Hartford. Honorable Mention—Mrs. Lewis Giffin, 16 Belcrest Road, West Hartford.

Photography—Mrs. Ernest Rosenthal, 17 Pine Road, West Hartford.

Children—Miss Sidney Giffin, 16 Belcrest Road, West Hartford. Honorable Mention: Miss Ann Levenson, 49 Blackman Place, Bridgeport.

CONNECTICUT PHYSICIANS' ART ASSOCIATION 1952 EXHIBITORS

HARTFORD COUNTY

Betty Edson (Daughter of Dr. R. C. Edson)	Windsor	Seascape	Oil
Dr. James R. Miller	West Hartford	R.F.D. Granby	Oil
		Chatham Harbor	Oil
Mrs. James R. Miller		African Violets	Oil
		Winter Road	Oil
Dr. Francis Helfrick	Manchester	Innominate Bone	Charcoal
Mrs. Gerald Greene	West Hartford	Michele When She Had Braids	Sculpture
Eric Greene (Son of Dr. Gerald Greene)		Stripe Design	Tempera
Samuel Antupit (Son of Dr. Louis Antupit)	West Hartford	A Penny For His Thoughts	Photograph
Frances Antupit (Daughter of Dr. Louis Antupit)		Bedtime Snack	Oil
		Refreshments	Oil
Mrs. Louis Antupit		Tea Time	Oil
		Ubangi Head	Oil
Mrs. Nicholas St. John	Wethersfield	Attic Relics	Oil
Mrs. John Churchill	West Hartford	Arrangement	Oil
Mrs. Ernest Rosenthal	West Hartford	Sunset	Photograph
		Monday in Havana	Water color
Stephen Rosenthal (Son of Dr. Ernest Rosenthal)		Fishing Shacks	Water color
Mrs. Frederick Ellison	West Hartford	Still Life	Oil
Dr. Walter Grossman	Hartford	Portrait of a Young Rabbi	Oil
Mrs. Charles T. Schechtman	New Britain	Grecian	Charcoal
		Winter Scene, Copy	Charcoal
Rebecca Schechtman (Daughter of Dr. C. Schechtman)		My Pets, Copy	Oil
		Ballet	Oil
Mrs. Joseph Dushane	West Hartford	Sea Sprung	Oil
Mrs. E. H. Crosby	Hartford	North Truro	Water color
		Modern Mosaic	Oil
Mrs. Nicholas A. Marinaro	Newington	Angelica	Oil
		Early Spring	Water color
Mrs. Merrill Rubinow	Manchester	Coal Yard	Pen and Ink
		The City	Pen and ink wash
Dr. W. W. Wright	West Hartford	Convalescence in Manhattan	Oil
		Progress	Gouache
Mrs. Lewis Giffin	West Hartford	Mary Alice	Bas relief
		Jean	Bas relief
Sidney Giffin (Daughter of Dr. Lewis Giffin)		Artist	Tempera
Mrs. David Waskowitz	New Britain	Kenneth	Oil
		Mrs. Anderson	Oil

NEW HAVEN COUNTY

Dr. F. W. Roberts	New Haven	Mrs. Burnham	Oil
		Mrs. Du Mortier	Oil
Dr. Stephen Magyar	New Haven	Bela	Oil
		Mark	Oil
Dr. Saxton Burr	New Haven	Pool's Edge	Oil
Lu Verstandig (Daughter of Dr. Charles Verstandig)	Hamden	Brooklyn Bridge	Black and white
Maurice Wakeman (Son of Dr. E. Wakeman)	Bethany	St. Mary's Lake	Photograph
Dr. John Freiheit	Waterbury	Oil portrait	Children
		Mrs. F.	Oil
Mrs. John Freiheit		Still Life	Charcoal
		Still Life	Charcoal
Mrs. S. B. Rentsch	Derby	Flame	Sculpture
		A Song of Praise	Sculpture
Mrs. Orvan Hess	North Haven	The Matterhorn	Oil
		Sept. Swan Song	Oil

Dr. Orvan Hess	North Haven	Dog	Oil
		The River	Oil
Dr. Herbert Thoms	New Haven	The Uplands	Water color
		Red Barns	Water color
Dr. John Foster	Waterbury	Pewter Plate	Pastel
Mrs. Samuel Climo	New Haven	Seal's Siesta	Ceramic
		Pinch Pots	Ceramic
Samuel Climo (Son of Dr. S. Climo)		For Sail	Oil
Katherine Wakeman (Daughter of Dr. E. Wakeman)	Bethany	Mother and Child	Oil
Mrs. Harry Conte	New Haven	Copy	Oil
		Copy	Oil
Mrs. Bernard Brody	Hamden	Seagrape & Driftman	Oil
		Phantom Forest	Oil
Mrs. Walter Russell	New Haven	Buffy	Oil
		Midnight Call	Oil
Dr. H. E. Allen	Waterbury	Anticipation	Oil
		Sea Remnants	Oil
Mrs. Wilson Powell	Hamden	My Favorite Doctor	Oil
		Chrysanthemums	Oil

LITCHFIELD COUNTY

Dr. Royal Meyers	Watertown	Winter Scene	Oil
		At Anchor	Oil
Mrs. Lincoln Opper	Torrington	Ceramic	
		Sketch	Pen and ink
Mrs. Robert Sellew	Canaan	Sea Gulls	Oil
		Hurry Call	Oil
Mrs. D. P. Samson	Thomaston	Cytology	Black and white
		Cytology	Black and white

WINDHAM COUNTY

Dr. Karl T. Phillips	Putnam	The Doctor	Marquetry

NEW LONDON COUNTY

Mrs. Edward Gipstein	New London	La Patrons, Copy	Oil
		Citadel in the Alps	Oil
Mrs. M. L. O'Neil	Jewett City	From A Picture Window	Oil
		Still Life—Dogwood	Oil
Mrs. Emile Szlemko	Groton	Study of Dancer	Oil
		Girl and Basket	Oil
Mrs. Tage M. Nielsen	New London	Apple Branch and Pitcher	Oil

FAIRFIELD COUNTY

Dr. Charles W. Perkins	Norwalk	Rennie and Princess Pat	Photograph
		Meditation	Photograph
Mrs. Harold Kleinman	Bridgeport	Laughing Girl	Charcoal
		Aphrodite	Water color
Phyllis K. Hampton (Daughter of Dr. L. Hampton)	Stratford	Lordship Beach	Oil
Ann Levenson (Daughter of A. Levenson)	Bridgeport	Man	Charcoal
		Dog	Charcoal
Mrs. Saul B. Meltzer	Fairfield	Still Life	Oil
Dr. J. Nemoitin	Stamford	Jewish Rabbi	Photograph
Dr. Joseph Esposito	Bridgeport	Calendar Harbor, Copy	Oil
		11 P. M., Copy	Oil

MIDDLESEX COUNTY

Mrs. Joseph Magnano	Middletown	Fall	Oil
		New England Winter, Copy	Oil
Dr. Philip Berwick	Moodus	ETO Sunset	Water color
		France, 1944	Water color
Luisa Alexander (Daughter of Dr. S. Alexander)	Portland	Still Life	Oil
		Copy	Oil
Elaine Roccapriore	Middletown	A Bird	Pastel
		Flowers	Pastel

CONNECTICUT MEDICAL SERVICE

WILLIAM H. HORTON, M.D., *General Manager and Director of Medical Services*

CONNECTICUT MEDICAL SERVICE ENROLLS 500,000th MEMBER

Connecticut Medical Service celebrated several events in its history of significance to every citizen in Connecticut at a special dinner held at the New Haven Lawn Club on May 15. On this occasion a national achievement award was presented to CMS in recognition of its reaching an enrollment of 500,000; one-fourth the population of the State of Connecticut. Eugene E. Graytak an employee of the Patmore Millwork, Inc. of Bridgeport, became the 500,000th CMS member. Also Frank Hart, an employee of the Wallace Barnes Division of the Associated Spring Corporation, Bristol became the 23,000,000th member of the National Blue Shield Organization.

On this same occasion Thomas J. Danaher, M.D., president of CMS Professional Policy Committee announced that beginning June 1, 1952 CMS surgical plan will include payments for physicians' visits at the hospital in the treatment of medical cases, excluding the first three day and continuing to a total of 21 days during 1952.

President Judd of Connecticut Medical Service delivered the address of welcome. He paid tribute to the participating physicians, to the employers, to Connecticut Hospital Service, and in particular to the Commissioner of Insurance, Mr. Ellery Allyn and his staff. Mr. Judd said: "We believe strongly that our formula for the practical support of our American form of medical practice, through cooperation of the medical profession with the lay community, is in the best sense a fine example of free enterprise, contributing towards a practical solution of a problem of great social significance worked out at a local level."



Frank Hart, 10 year employee of the Wallace Barnes Division of the Associated Spring Corporation, Bristol, Connecticut who became the 23,000,000th member of the National Blue Shield Organization at the CMS dinner on May 15

THE CONTRIBUTION OF THE PARTICIPATING PHYSICIANS TO CMS

The success of CMS is due to the efforts of many individuals and groups. Tribute is due the parent organizations, the Connecticut State Medical Society and Connecticut Blue Cross—the individuals on the respective committees and executives of both groups for their work in starting the Corporation.

Credit is due to the Board of Directors of CMS, the Professional Policy Committee, the executives, past and present, for their excellent management of the enterprise. The sales agent, Connecticut Blue Cross, the employers of Connecticut, organized labor, the people of Connecticut who have purchased the plan have all made their contribution.

The individuals to whom I wish to pay special tribute have contributed more than anyone else to

Remarks by Thomas J. Danaher, M.D., at the Connecticut Medical Service dinner on May 15, 1952.



Mr. L. Graham Patmore, President, Patmore Millwork, Inc., congratulates his employee, Mr. Eugene E. Graytak, the 500,000th CMS member

the success of the plan; they are the participating physicians of Connecticut.

It must always be remembered, except for a cash asset of $10,000 contributed by the parent organizations, the enterprise actually became a reality only because a sufficient number of physicians agreed to participate in the plan and guarantee its solvency. The physicians signed agreements that they would accept the amounts designated in the fee schedule as full payment for the surgical and obstetrical procedures covered in the plan for subscribers in the lower income levels. These payments were less than the usual ones received by physicians for these types of services. In addition, the physicians agreed to participate for at least one year and sixty days; and, if the financial welfare of the plan required, to accept a proration of the fees for the procedures included in the contract.

Now these agreements were sizeable commitments, and it is readily apparent that although it took some time for the physicians to decide to establish a medical care plan, when they did start one, they accepted full professional and financial responsibility for it.

Six weeks after agreements were sent to the physicians of Connecticut, a sufficient number were signed so that the plan could be in operation. At present there are over 1,800 Connecticut physicians who are participating, and in the past three years, only thirty-two have resigned—the majority of these were due to retirement from practice.

As chairman of the Professional Policy Committee, I have had the opportunity to observe how the physicians have fulfilled their agreements. On many occasions there have been honest differences of opinions between the committees and physicians or between practicing physicians themselves as to how certain operations could be equitably paid for; we of the committee have never felt ourselves to be infallible in our judgment. It is most important to note the assistance which has been rendered CMS by the constructive criticisms of its participating physicians who after all, more than any of the official committees, are really CMS. It would take less than the 10 fingers on my two hands to enumerate all of the participating physicians who have been uncooperative.

During the past few years our statistics show that approximately fifty per cent of our claims were paid as service benefit cases, that is, their income was below the prescribed level so that no additional charge was made by the participating physicians. The remainder of the claims involved subscribers whose income was above the service level and, therefore, the physician was entitled to make any additional charge he felt to be reasonable. It is extremely interesting to note that in eleven per cent of the cases the physician did not choose to make any additional charge and thus these allowance cases also received service benefits. It must be remembered too our first fee schedule contained many inequities; many of these have now been corrected. In spite of this handicap our physicians continued to cooperate with the plan. Connecticut physicians have demonstrated in a practical manner that they are more interested in their patients' welfare than they are in their own personal gain.

Many of our participating physicians as well as subscribers have been critical of the fact that CMS allowed a method of prepayment for surgery and obstetrics, but not for medical conditions; for example, prepayment was possible for an appendectomy, however, if a subscriber had a heart attack, he could not avail himself of any benefits. The Board of Directors of CMS also realized this defect in the plan but were unwilling to undertake any expansion of the plan during the early years of corporate life.

Tonight it is my privilege to announce that the Board of Directors of CMS, with the approval of the Insurance Commissioner of Connecticut and the House of Delegates of the Connecticut State Medical Society, has authorized payment of additional benefits for the professional services of physicians ren-

dered in a general hospital for the treatment of medical diseases without any increase in premium.

These additional benefits are:

1. Payment at the rate of $3 for each day the physician visits a patient while he is hospitalized, for the treatment of any medical (nonsurgical) condition beginning on the fourth day of each hospital admission and continuing thereafter, not to exceed a total of 21 payable days during 1952.

2. Benefits will continue to be available not to exceed 21 payable days during 1953, subject to review by the Board of Directors at the Annual Meeting on March 17, 1953.

3. Service benefits will apply to all patients who are eligible (as with the surgical-obstetrical contract) for the period of hospitalization covered by CMS.

The details regarding these additional benefits will appear in all of the daily newspapers of Connecticut tomorrow and will be repeated before the additional benefits become effective on June 1, 1952.

FROM THE ANNUAL REPORT OF THE DIRECTOR OF CMS

THE AMENDED CONTRACT

An amended contract was offered members on April 1. This contract included higher, more realistic income levels for Service Benefits; readjusted surgical fees; and an expanded fee schedule.

A section arrangement made possible additional benefits to members when illness of a catastrophic nature required multiple operations in several areas of the body. Under this provision, 27 members received benefits of from $50 to $200 in addition to the $250 basic liability. These benefits could not have been paid under the original contract since all of the operations in each case, were performed "during the same period of disability resulting from the original operation," or "were due to the same cause or causes." Similarly, most of the current commercial contracts would not be able to pay in excess of their basic contract liability for the same reasons.

The premium increase for the amended contract was moderate, and the experience under the new contract has shown the underwriting to be extremely sound.

SERVICE BENEFITS

Of a total of 50,573 paid claims, 22,062 claims (44 per cent) were paid as Service Benefits. Further, no additional charge was made to 6,500 members by the Participating Physician even though the claim was paid as an indemnity; thus, they too received Service Benefits, a grand total of 28,562 or 56 per cent of total claims paid.

ADMINISTRATIVE EXPENSE

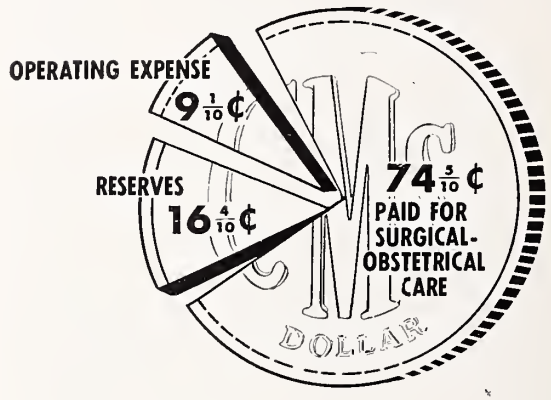
The cost of operating CMS during 1951 was $375,863.34 or 9.1 per cent of earnings. This figure reflects a decrease of 1.2 per cent from the 1950 cost; the comparative figures for all years are:

1949	1950	1951
13%	10.3%	9.1%

The total operating expense is divided into two categories, the direct expense of functions managed by CMS, (the review, processing, correspondence, and payment of claims;) and the services purchased from Connecticut Blue Cross (enrollment, billing, and collections of premium) under the agency function agreement.

CMS direct	$106,113.31	2.6%
Blue Cross	269,750.03	6.5%
Total Operating Expense	$375,863.34	9.1%

HOW THE MEMBERS' DOLLAR WAS SPENT IN 1951



MEMBERSHIP SUMMARY

There was a net increase of 57,467 members in CMS during 1951. A net loss of 11,287 members was experienced following the April 1 effective date of the amended contract. This figure is felt to be nominal and considerably less than had been anticipated on a major contract revision.

Under the amended contract membership has grown slowly but steadily and at the year end totaled 459,752 members.

DIRECT PAYMENT OFFERING OF CMS

On August 15, the Board of Directors authorized an offering of membership in CMS to all persons who were members of Connecticut Blue Cross on a quarterly direct payment basis.

While definite figures will not be available on the complete offering until early in 1952, it seems apparent that if this acceptance rate continues through all cycles, approximately 55,000 members will be added to CMS membership.

EMPLOYER COOPERATION

Over 4,757 companies now have the complete protection of both CMS and Blue Cross or 51 per cent of all firms that have Blue Cross coverage.

FINANCIAL EXPERIENCE

The additonal membership during the year and the new premium rates which became effective April 1, resulted in a marked increase in total income to $4,135,018.

Despite the upward revision of some important surgical fees such as maternity delivery and tonsillectomy and adnoidectomy, the enlargement of the fee schedule, and the section-arrangement of the contract, the total surgical-obstetrical expense was 74.5 per cent. Maternity expense increased in 1951 and both maternity and surgical expense are expected to show increases during 1952.

Maternity reserves (legally required by the contract) were increased by $205,605 (5 per cent of income) and $504,181 (12.2 per cent) were added to reserves for contingencies. As of December 31, 1951, CMS had the equivalent in unallocated reserves of 1.89 months of premium earnings. (Optimal status; six months' premium in reserve.)

The financial statement is considered to reflect a very satisfactory financial status as the Corporation concludes its third calendar year of operation.

ANNUAL FINANCIAL STATEMENT

DECEMBER 31, 1951

BALANCE SHEET

ASSETS

Cash		
Commercial Accounts	$860,973.26	
Office Funds	50.00	
		$ 861,023.26
Investments		
U. S. Government Securities (Cost)		853,140.63
Premiums Due from Connecticut Hospital Service, Inc., for Subscriptions Collected		101,382.40
Premiums Receivable		6,044.85
Accrued Interest Receivable		8,500.00
Furniture and Fixtures		1.00
Total		$1,830,092.14

LIABILITIES

Taxes Payable		
Federal Old Age Benefits	$ 108.69	
Withholding Tax	836.00	
State and Federal Unemployment Compensation	401.21	
		$ 1,345.90
Accounts Payable		2,032.72
Employees' Deductions—Savings Bonds		63.00
Accrued Salaries		128.40
Agency Expenses Payable		25,767.91
Unearned Premiums		221,129.09
Accrued Surgical Care		359,123.00
Reserve for Maternity Care		496,125.00
Reserve for Contingencies		724,377.12
Total		$1,830,092.14

STATEMENT OF INCOME AND EXPENSE

Earnings:		
Net Premiums Earned	$4,041,598.54	
Subscribers' Adjusted Premiums	85,804.51	
Total Premium Earnings	$4,127,403.05	(100.0%)
Expenses:		
Surgical Care Expense	$3,074,210.00	(74.5%)
Operating Expense:		
Salaries	55,035.09	
Printing and Stationery	17,563.39	
Postage	6,390.21	
Office Supplies and Expense	1,176.86	
State and Federal Unemployment Tax—Employer	1,234.89	
Federal Old Age Tax—Employer	644.47	
Public Information	14,473.12	
Travel and Business	4,424.09	
Insurance Expense	163.86	
Telephone and Telegraph	801.63	
Professional Services	1,400.31	
Dues and Subscriptions	2,804.85	
Direct Expenses	$ 106,113.31	(2.6%)
Blue Cross Agency and Managerial Expense	269,750.03	(6.5%)
Total Operating Expense	$ 375,863.34	(9.1%)
Net Operating Gain	$ 677,329.71	(16.4%)
Other Income	$ 7,615.23	(.2%)
Excess of Earnings Over Expenses	$ 684,944.94	(16.6%)

CMS BECOMES A BLUE SHIELD PLAN

The Board of Directors voted to apply for membership in Blue Shield Medical Care Plans, Inc. at their meeting on May 21. The Blue Shield Commission approved the application on June 17 and Connecticut Medical Service became the 76th nonprofit, prepaid, medical care plan to affiliate. The latest available figures indicate that Connecticut Medical Service is the 11th largest Blue Shield Medical Care Plan in the United States and Canada.

INHOSPITAL MEDICAL CARE (PROPOSED)

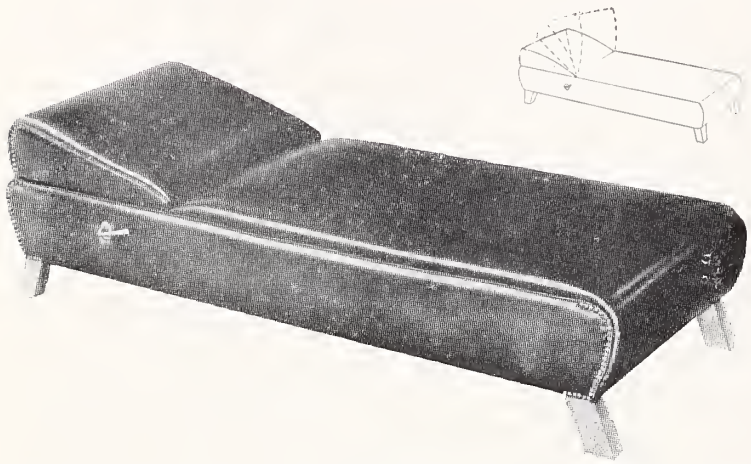
At the time of the establishment of CMS it was intended that eventually the member's contract would include in-hospital medical care as well as surgical-obstetrical benefits. With the continued successful operation of CMS there has been an increasing demand from both members and Participating Physicians to include medical as well as surgical benefits in our coverage. Studies have been in progress since September at the direction of the Professional Policy Committee, and it is expected that an initial program of inhospital medical care will be announced during 1952.

PAYMENTS FOR PHYSICIANS' SERVICES

by years	CLAIM	AMOUNT
1949	6,329	$ 366,312
1950	28,351	1,580,757
1951	50,573	2,942,560
Totals	85,253	$4,889,629

American Surgical

SUPPLY ANI



LOUNGEASE RECOVERY COUCH

STURDILY BUILT . . . IDEAL FOR:

- RECOVERY THERAPY • FIRST AID
- REST ROOMS • INDUSTRIAL PLANTS
- EXECUTIVE OFFICES
- SUN PORCH

TRY IT

Microtherm's many advantages clude:

No tuning—no electrodes—no pa no shocks or arcs—no contact betw patient and directors.

Mobile—may readily be moved f room to room.

Penetrating energy for deep heati

Effective production of act hyperemia.

Controlled application over large small areas.

Cabinet has ample storage space accessories.

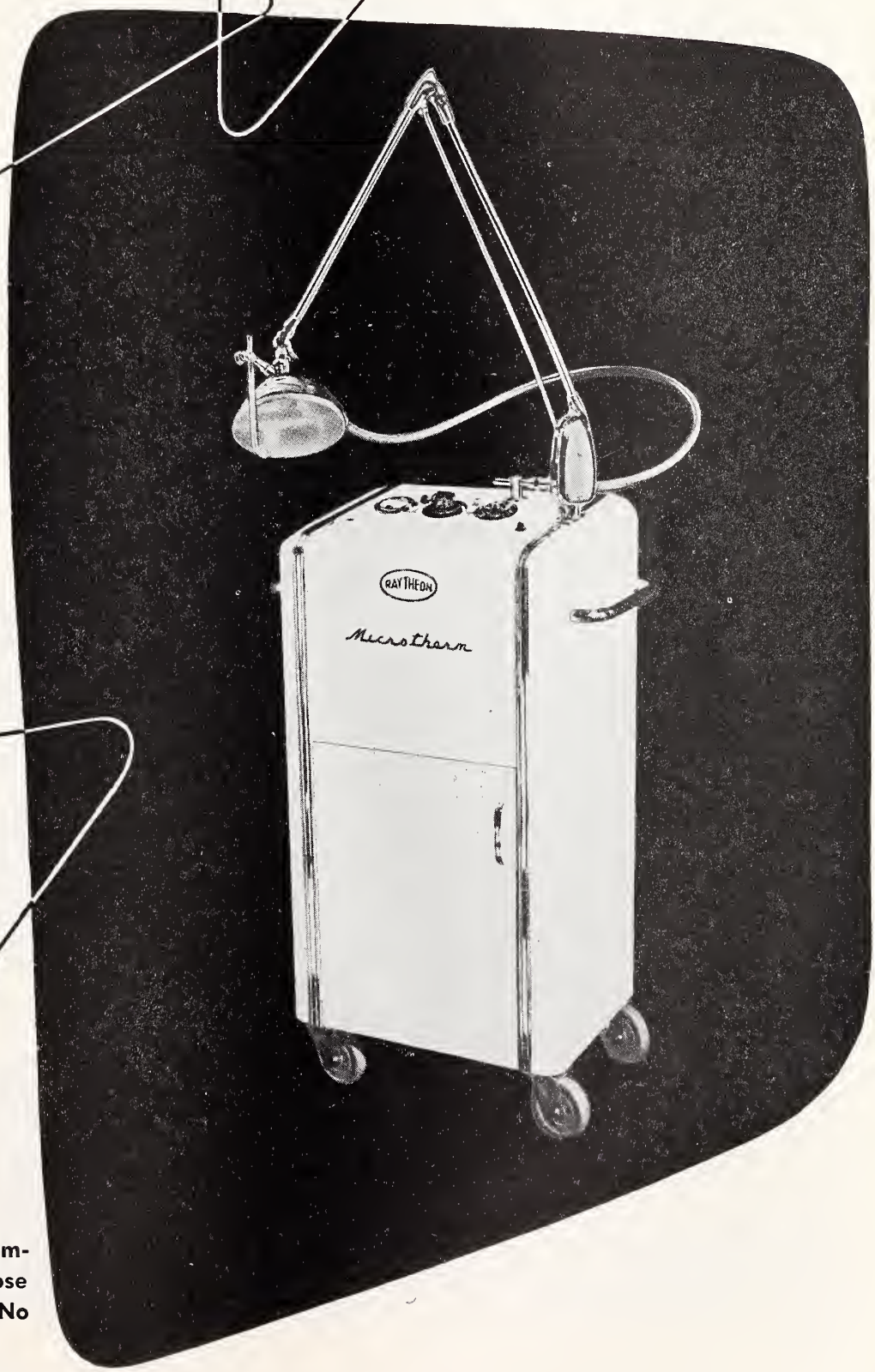
Maximum of flexibility permits stantaneous and permanent finger positioning.



*Registered U.S. PAT. OFF.

P. O. BOX 150 : Bpt. 5-3116 or ENTERPRISE 3190 1715 BA

ENT COMPANY *presents*



RAYTHEON

RMY

NO TANGLE WITH TELEVISION

(*Raytheon Radar* Microtherm employs frequencies *far* above those of the television wave range. No danger of interference.)

E. : BRIDGEPORT, CONN.

by participation	PARTICIPATING	NON-PARTICIPATING*
1949	$ 310,021	$ 56,291
1950	1,342,069	238,688
1951	2,472,596	469,964
Totals	$4,124,686	$764,943

*Paid to Member (including out of state physicians)

PARTICIPATING PHYSICIANS

by geographic area

	CASES		AMOUNT PAID	
Fairfield	5,930	13.8%	$ 352,276	14.2%
Hartford	12,022	27.9%	753,653	30.5%
Litchfield	3,300	7.7%	173,900	7.0%
Middlesex	1,404	3.3%	84,583	3.4%
New Haven	16,667	38.8%	929,325	37.6%
New London	2,773	6.4%	127,536	5.2%
Tolland	217	.5%	12,017	.5%
Windham	708	1.6%	38,996	1.6%
Out of State	13	.....	310	.....
Totals	43,034	100.0%	$2,472,596	100.0%

Distribution of Cases Paid by Type of Surgery

	1951 NO. OF CASES	PER CENT	AMOUNT PAID	PER CENT
Miscellaneous surgery				
Thyroidectomies	274	.5	$ 41,605	1.4
Varicose vein ligations	687	1.4	74,108	2.5
Thoracic surgery	788	1.6	25,885	.9
Abdominal surgery				
Appendectomies	1,837	3.6	184,236	6.2
Cholecystectomies	768	1.5	128,495	4.4
Herniorrhaphies	1,297	2.6	150,025	5.1
Other abdominal	1,356	2.7	78,134	2.7
Proctology				
Hemorrhoidectomies	1,198	2.4	86,110	2.9
Urology				
Cystoscopies	1,813	3.6	48,795	1.7
Prostatectomies	239	.5	34,935	1.2
Obstetrics	8,701	17.2	619,986	21.1
Gynecology				
Hysterectomies	1,161	2.3	190,515	6.5
Perineorrhaphies	265	.5	85,495	2.9
Vaginal plastic	251	.5	36,595	1.2
Ophthalmology	1,488	2.9	71,171	2.4
Ear, Nose and Throat				
Tonsillectomies	5,990	11.8	195,923	6.7
Neuro surgery	689	1.4	55,868	1.9
Fractures	2,272	4.5	129,108	4.4
Traumatic wounds	2,277	4.5	38,718	1.3
Tumors	1,752	3.5	40,739	1.4
All other surgery	15,470	30.5	626,114	21.1
Total	50,573	100.0	$2,942,560	100.0

Note: Only operations which were paid as independent procedures are included; when any of the above were performed as additional procedures, for which independent payment was not made, they do not appear in the above summary.

CLAIM EXPERIENCE

Claims reviewed for payment averaged over 1,000 each week. 15,893 more claims were paid during the year than had been paid in the two previous years combined.

The prompt payment of claims which has been an outstanding characteristic of CMS since its beginning was continued throughout the year. An average of 94 per cent of all claims were paid forty-eight hours after their receipt in the Home Office, an additional 3 per cent (which required further review) were paid in the next twenty-four hours and 3 per cent of the claims were referred to the Professional Policy Committee.

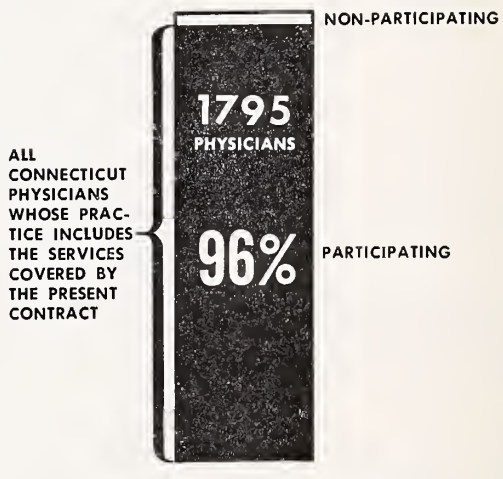
PROFESSIONAL POLICY COMMITTEE

Meetings of the Committee were held each month, except August, for the consideration of professional problems and claims involving discretionary fees. The Members continued their very faithful attendance and each member participated in the discussions of the various matters. The Committee is to be commended on its efforts to establish equitable policies for the handling of claims from Participating Physicians.

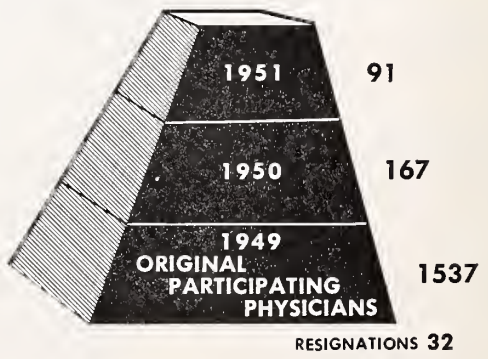
PARTICIPATING PHYSICIANS

The number of Participating Physicians has constantly increased and has now attained the very significant figure of 96 per cent of all Connecticut physicians whose professional services are covered by the contract. The practical contribution which the Participating Physician voluntarily makes to the welfare of his patient cannot be over emphasized.

Participation by Physicians: Present Status



Participation by Physicians: Increase by Years



The Activities of the United States Chapter of the International College of Surgeons

A Statements of Facts

1. The United States Chapter of the International College of Surgeons is chartered by the International College of Surgeons (founded in Geneva, Switzerland in 1935) and exists by virtue of that charter and is an integral part of that organization. It is bound to adhere to the rules, regulations, mandates and constitution and by-laws that govern the parent body. The International College was conceived and organized as an instrument of democracy in science on a world-wide scale.

2. In its existence of seventeen years, the International College of Surgeons has had great success as an educational institution. It has established chapters and representatives throughout the world and is under the leadership of some of the world's most outstanding surgeons. The International President is Professor Hans Finsterer of the University of Vienna; the International First Vice-President is Professor Rudolph Nissen of New York and the University of Basel, Switzerland. The reputation of these leaders in surgery and the great number of other distinguished exponents of College principles speak for themselves.

3. In the seventeen years of its existence, the College:

a. Has used its influence consistently toward world peace by promoting mutual understanding and good will among the surgeons of the world;

b. Has disseminated surgical knowledge and created a surgical brotherhood throughout the world;

c. Has established postgraduate courses, residency exchanges and Fellowships in the various specialties throughout the world;

d. Has provided vital war aid during World War II to many surgeons, members and non-members alike, by supplying food, instruments, suture material and other aid;

e. Has held successful Assemblies in New York, Philadelphia, Chicago, Cleveland, Detroit, Mexico City, Lima, Buenos Aires, Frankfurt, Rome, Florence, Torino, Vienna, Sao Paulo and many other centers, to the significant advancement of surgical knowledge in many nations;

f. Has purchased and maintains the College Home in Chicago, and publishes the Journal of the International College of Surgeons, a scientific monthly with world-wide circulation;

g. Was also the first and only College of Surgeons in the United States to set up written, oral, and clinical examinations for admission to Fellowship as one of the qualifying requirements. It consists of Junior and Associate members, who by degrees attain the Fellowship;

i. Its officers receive no salary whatever.

4. In the first few years, membership in the International College was accorded by merit. Later, at the International Assembly in Lima, Peru, the International House of Delegates adopted an amendment to the Constitution and By-Laws making it mandatory for each chapter in the world to create examining boards for the purpose of examining candidates as to their moral, ethical and professional qualification. That portion of the preamble reads as follows:

"It was decided that the International Board of Surgery would be established in the various chapters for the purpose of investigation and determination of the moral, ethical and professional fitness of each applicant for admission to Fellowship. Each chapter was authorized to formulate its requirements, in conformity with the regulations governing surgical practice of the respective country."

The results obtained within the United States Chapter since the inauguration of qualifying examinations for Fellowship in the International College of Surgeons are reflected in the appended analysis.

5. At no time has the United States Chapter entered into competition with any other group, nor has it interfered with the rights and prerogatives of the American Boards of Surgery or any other surgical organization. This is borne out by the fact that at no time has any other surgical organization, particularly the American Board of Surgery, voiced any criticism of its activities. Had the American Boards of Surgery or the American College of Surgeons, for example, done so at any time, their suggestions would have had the immediate attention of our Executive Council, and any part of our activities subject to justifiable criticism would have been rectified promptly. It is a fundamental desire and principle of the International College of Surgeons to cooperate with every existing surgical body. A large number of the Fellows of the American College of Surgeons are also Fellows of the International College of Surgeons, and an equally large number

are members of the American Boards of Surgery. There exists a splendid esprit de corps between the members of these organizations.

6. Regrettably, an astonishing resolution was recently circulated by the director of the American College of Surgeons, which is replete with misstatements.

7. To apprise the surgical profession of the facts, the following was published in the Journal of the American Medical Association:

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Vol. 148, No. 5, Page 397

CORRESPONDENCE

INTERNATIONAL COLLEGE OF SURGEONS

To the Editor:

In order to clarify certain misconceptions based on unfounded rumors concerning the Qualification Board of the International College of Surgeons, it is our desire to reemphasize the functions of our examining board.

The qualifying examinations we established in 1946 are in no way intended to invade the province of the American Boards of Surgery or any other national boards. These rigid examinations have been created for the specific purpose of establishing the qualifications of those applying for membership in the International College of Surgeons exclusively. At no time has the International College of Surgeons been in competition with any surgical organization. As a matter of fact, the vast majority of our Fellows are also members of other existing boards and organizations approved by the American Medical Association and the Advisory Board for Medical Specialties.

United States Chapter
(International College of Surgeons)
Henry W. Meyerding, M.D., President
Rochester, Minnesota
Arnold S. Jackson, M.D., Secretary
Madison, Wisconsin

8. At a meeting of the executive council of the United States Chapter of the International College of Surgeons held in Chicago on January 26, 1952, a resolution was unanimously approved requesting the Board of Trustees of the American Medical Association to appoint a Fact-finding Committee to meet with representatives of the International College of Surgeons to examine the facts and initiate any necessary mediation without delay.

This request was granted. The committee appointed by the American Medical Association consisted of Dr. George Lull, secretary; Dr. Elmer Henderson, past-president; and Dr. Louis A. Bauer, president-elect, of that body. The committee appointed by the International College of Surgeons was composed of Dr. William Carpenter MacCarty, Sr. of Rochester, Minnesota, Dr. Gilbert Douglas, F.A.C.S., F.I.C.S. of the University of Birmingham, Alabama, and Dr. Henry J. Oberhelman, F.A.C.S., F.I.C.S., head of the Department of Surgery of Loyola University Medical School of Chicago.

This Committee was instructed by the Executive Council of the United States Chapter to abide by every recommendation of the Fact-finding Committee of the American Medical Association and to spare no effort toward a thorough understanding; also, to draft in lieu of the certificates issued heretofore, a new certificate for qualification for Fellowship in the International College of Surgeons which was approved by the Fact-finding Committee with deletion of the terms board and certified and to attest only that the applicant has successfully passed the required examinations and complied with all the requirements which qualify his being entitled to be enrolled into the Fellowship of the International College of Surgeons.

9. This was done in order to avoid willful misinterpretation by an occasional agitator from which no organization is immune. It is hard to see how cooperation could go further. The action of the United States Chapter leaves no possible doubt as to the keen desire of the International College of Surgeons to avoid interorganizational friction, and pursue the hitherto peaceful and cooperative relations with all other surgical groups.

10. As a further step toward mutual understanding, the Fact-finding Committee of the American Medical Association requested representation from the American College of Surgeons to iron out any existing differences. This request has met with refusal.

11. Our endeavors are sincere, and the issuance of this statement is a genuine attempt to state the facts as they are. Documentations of every statement herein may be obtained by application to the Secretariat of the International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

12. It is our earnest desire that the rapid strides made by the International College of Surgeons throughout the world will continue to be furthered by the understanding and good will of all surgeons of the United States and Canada. Particularly in these times, with the menacing shadows of socialized medicine and Communism over our heads, cooperation among professional men is a *sine qua non*.

A word of gratitude is in order here for the many warm letters since Dr. Hawley's communication; they are replete with heartening tributes to the ideals, standards, progress, and activities of the International College of Surgeons.

William Carpenter MacCarty, Sr., M.D., F.A.C.P., F.I.C.S. (Hon.)
International Representative-at-large
Member, International Board of Trustees,
Chairman, Fact-finding Committee of the United States Chapter, International College of Surgeons,
Rochester, Minnesota

Licensing of Foreign Medical Graduates in Connecticut

CREIGHTON BARKER, M.D.
Secretary to Connecticut Medical Examining Board

This is a report of the experience of graduates of foreign medical schools, exclusive of Canada, before the Connecticut Medical Examining Board from 1937 through 1951 which represents the period of heavy migration of foreign physicians into the United States.

The first column shows the number of candidates from each school that presented themselves for examination. The second column shows the number of examinations that these candidates took and the final column states the number of individuals who were successful in passing the examinations. The overall failure rate is 69.6 per cent.

	TOTAL CANDIDATES	TOTAL EXAMINATIONS	TOTAL PASSES
Austria			
Graz	1	4	1
Vienna	39	95	21
Chile			
Chile	2	2	1
Cuba			
Havana	5	7	5
Czechoslovakia			
Charles	3	5	2
Prague	9	14	1
Denmark			
Copenhagen	2	4	2
France			
Paris	8	11	8
Germany			
Berlin	8	15	6
Breslau	4	7	1
Cologne	1	1	1
Erlangen	2	2	1
Frankfurt	5	6	2
Freiburg	1	1	1
Gottingen	3	3	1
Halle	1	1	0
Hamburg	1	2	1
Heidelberg	5	10	2
Jena	1	2	0
Konigsberg	1	1	0
Leipzig	2	4	2
Munich	10	17	4
Rostock	1	2	0
Tubingen	1	5	0
Greece			
Athens	1	5	0
Holland			
Utrecht	1	3	1
Hungary			
Budapest	6	20	4
Pecs	5	9	3
Ireland			
National University	1	1	1
Queens	1	1	1
Italy			
Bologna	6	26	2
Florence	1	1	1
Naples	11	32	8
Padova	3	3	1
Rome	13	27	10
Lebanon			
Beirut	4	4	4
Mexico			
Mexico	3	7	3
Poland			
Wilna	1	4	0
Scotland			
Aberdeen	1	1	1
Glasgow	1	1	1
Switzerland			
Basle	4	4	4
Bern	6	11	5
Geneva	5	14	4
Lausanne	1	2	1
Zurich	4	4	4
Grand total	195	401	122

Elected to College of Physicians

At its annual meeting in April the American College of Physicians elected to membership as Fellows from Connecticut Maurice R. Moore of Norwich and Frederick C. Weber, Jr. of Greenwich. The following were elected Associates: Daniel B. Arst, Newington; Nila B. Covalt, East Hampton; David H. Fogel, Stamford; Dwight Griswold, Hartford; James J. Moher, Hartford.

A.M.E.F. NEWS

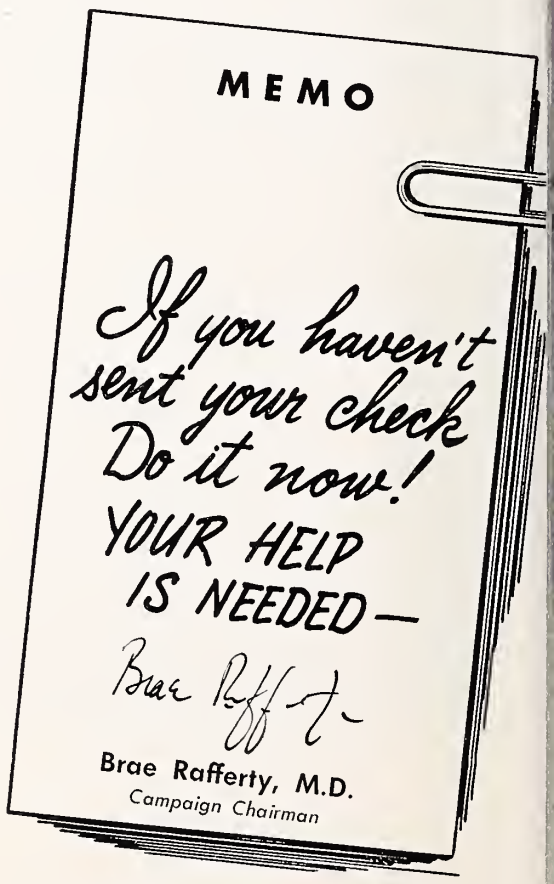
Fund Raising Committee

CONNECTICUT STATE MEDICAL SOCIE

The 1952 campaign of the American Medical Education Foundation will soon reach a peak of activity in every state.

The goal is to obtain as many physician contributions as possible by June 30, the date set for a national tabulation of campaign results.

Every check written before June 30 will help Connecticut gain a leading place in the campaign.



Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please send a pledge card and information concerning the American Medical Education Foundation.

Name .....

Office Address .....

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Plans for National PR Workshop Being Studied

A study to determine the need for a national workshop conference on medical public relations is being conducted by the Public Relations Section of the American Medical Association.

Results of a questionnaire poll of 168 state and county medical associations indicates strong support for a two-day workshop session in addition to the general public relations conference that has featured the American Medical Association's semi-annual meetings during the past four years.

Fifty-two of the 79 associations reporting voted for this type of conference, while 18 associations indicated interest only in a general conference and others expressed no preference.

First place on the list of subjects for workshop discussion went to community relations, with 62 votes. Press-radio relations received 52 votes, speakers' bureau activities 44 votes and meeting promotion 43 votes. Other subjects in the lead included newspaper advertising, printing production, direct mail procedures, newsletter editing and field representative activities.

Two New Projects in Middlesex County

The Committee on Public Relations of the Middlesex County Medical Association has initiated two new projects for dissemination of information concerning the purposes and activities of medical organizations.

Dr. Harry C. Knight, committee chairman, has explained that one project is intended for community leaders in Middletown and adjacent communities, while the other will be developed for students at Wesleyan University. Kits of pamphlets and other materials have been prepared for both projects through the public relations offices of the State Medical Society and the American Medical Association.

Connecticut Theaters Present Health Education Film

Theaters throughout Connecticut are participating in an educational program on the importance of weight control as a factor in maintaining good health. The film being used in the program is a ten minute sound color cartoon titled "Cheers for Chubby" and was produced by the Metropolitan Life Insurance Company in cooperation with the American Medical Association. The film has been endorsed by the State Medical Society for educational purposes, a procedure also followed by medical associations in other states. The film was shown during May in New Haven, Bridgeport, Southington, Moosup, Rockville, Taftville, East Hartford and New Britain. It is scheduled for theaters in other communities through June and July.

Plan to Increase Hartford Emergency Panel

The Hartford County Medical Association is advancing a program to increase the number of physicians available for emergency calls in the Hartford area.

The emergency system being operated in cooperation with the Hartford Medical Society received 130 evening calls during the month of March and 26 of these were serviced by one physician. Twenty-seven of the 45 panel members answered one call and eight physicians responded to two calls during the period.

Waterbury Pharmacists Initiate Community Program

The Waterbury Druggists' Association recently sponsored a dinner meeting for physicians and

pharmacists as part of a community program to advance cooperative relationships. Principal speakers were Dr. Barnett Greenhouse, New Haven, chairman of the Conference Committee of the State Medical Society and the Connecticut Pharmaceutical Association, and Professor Nicholas Fenney, University of Connecticut College of Pharmacy.

Chicago Surgeon Gives Course in Nasal Reconstructive Surgery

For three days beginning April 24 the Hartford Hospital sponsored a refresher course in Reconstructive Surgery of the Nasal Septum under the direction of Maurice Cottle, professor of otolaryngology of the University of Chicago Medical School. Members of Hartford Hospital and Yale University Medical School staffs who had previously taken the intensive 14 hours a day, 9 day course in Chicago in October, 1951 were also sponsors.

It has always been Dr. Cottle's belief that special courses such as he gives are not the completion of the training but the start, and he has spent considerable time going to various parts of the United States to give these three day refresher courses to his alumni to further stimulate interest and to aid in their training. Dr. Cottle has always been deeply interested in the function of the nasal septum and the correction of the pathological anatomical changes which cause nasal dysfunction. His work, because it often involves corrective work on the external nose, has been mislabeled too frequently "plastic surgery of the nose." This is unfortunate for the emphasis in plastic surgery is placed on the cosmetic appearance of the external nose, neglecting entirely the important function of the nose within.

Dr. Cottle's surgical approach is to make as few incisions within the nasal vestibule as possible. He is ever careful of the skin and mucous membrane so that both may be preserved as much as possible with a minimum amount of scarring. The bone and cartilagenous pieces are thinned and flattened so that they may be reposed between the layers of the membraneous septum in order to maintain its rigidity. Rigidity is the septum's most important function, limiting the turgescence of the turbinates in their normal cycle. The nose that can function normally as a breathing organ contributes greatly to the well being and efficiency of the individual. This reconstructive work on the nasal septum has its place in rhinology.

Another concept which Dr. Cottle emphasized was the active treatment of nasal injuries where the septum was displaced or fractured. He recommended open reduction, evacuation of hematomata, elevation of depressed bone in the early phase after trauma rather than waiting and allowing septal deviation to increase, altering external appearances of the nose and disturbing internal function, which can be corrected then only by more extensive procedures.

The three day conference was conducted by Dr. Cottle and his associates at the Hartford Hospital. One operating room was altered by the building of extra viewing stands. The 35 doctors were seated there, and with the help of field or opera glasses could watch the operative procedures exceedingly well. One operation was scheduled in the morning and another in the afternoon. Following each session pre- and postoperative patients were seen and discussed, and from Dr. Cottle's large library of excellent Kodachrome slides of the nose the theoretical and practical aspects were well visualized. Evening conferences were held each night in addition.

The course at Hartford Hospital was taken by several alumni from other parts of the United States in addition to the Connecticut otorhinolaryngologists who were interested in improving nasal function. Dr. Cottle has a fresh approach and a stimulating manner in the presentation of this subject. Throughout the discussions the psychological aspects of nasal dysfunction and deformities were also emphasized, and his fine philosophy always seemed present as an excellent background and a supporting structure to his discussions. Both the alumni of Dr. Cottle's Chicago course and the newcomers to his concepts and techniques were impressed by the efficiency of the hospital in the special arrangements in the operating room and in all other features allowing this course to run with maximum smoothness throughout each 14 hour session.

LIST OF PHYSICIANS ATTTENDING

Angelini, Hugo, Hartford
Arnold, Morton, Willimantic
Bordley, John E., Johns Hopkins Hospital, Baltimore
*Bornstein, Max, Louisville, Kentucky

(Continued on page 468)

Name Secretaries for Medical Education and Student Groups

Division of executive secretarial duties of two groups of the American Medical Association—the American Medical Education Foundation and the Student AMA—has been announced by the executive committee of the association's Board of Trustees. Activities of both groups have expanded to such an extent that one secretary no longer can serve both groups, it was stated.

Russell F. Staudacher, 37, of 13 Apple Lane, Park Forest, Illinois, who has been serving as secretary for both groups during the past year, will devote full time as executive secretary of the Student AMA and as executive editor of its publication, the *Journal of the Student AMA.*

Hiram W. Jones, 36, of 511 W. St. Charles Road, Elmhurst, Illinois, has been appointed executive secretary of the American Medical Education Foundation. He formerly was associated with the Research Council for Economic Security, Chicago, was director of finance for the Chicago region of the National Conference of Christians and Jews, and was director of fund raising for Community Relations Consultants, Inc., specializing in hospital fund raising.

The Student AMA, an organization of medical students, has approximately 10,000 members in 44 active chapters. About twelve additional provisional chapters will be accepted next December. The American Medical Education Foundation was organized to stimulate voluntary contributions from members of the medical profession for support of approved medical schools.

T.B. Sanatorium Facilities in Connecticut

Excerpts taken from Connecticut Tuberculosis Association Bulletin, April 1952, Paul S. Phelps, M.D.

There are only two facilities in Connecticut solely devoted to the treatment of tuberculous patients, Gaylord Farm Sanatorium and the five State Tuberculosis Sanatoria.

On the other hand, there are several temporary facilities which care for tuberculous patients waiting for a vacancy in a sanatorium. There are also veterans' facilities that admit patients for treatment and/or transfer. They do not restrict their patients to citizens of Connecticut.

There are also a fairly large number of beds devoted to the care of tuberculous patients in the mental institutions.

Finally, there are a few beds in our general hospitals occupied by known tuberculous patients from time to time, on a temporary basis. In this connection, 1 per cent to 3 per cent of patient admissions to general hospitals have unrecognized tuberculosis.

Bed capacity at Gaylord Farm Sanatorium is approximately 130 at present and with the addition of the new infirmary will be 145. At the five State Sanatoria the bed capacity is as follows: Cedarcrest 305; Laurel Heights 370; Undercliff 328; Uncas-on-Thames 422; Seaside 145.

The waiting list for admissions to the State Sanatoria at present numbers about 150.

There are other facilities available at this point on a temporary basis in the State for patients waiting sanatorium admission. Seventy of those patients waiting sanatorium admission are located in the following institutions:

Grace-New Haven Community Hospital, New Haven, 24 patients; Englewood Hospital, Bridgeport, 15 patients; Nathaniel Witheral Hospital, Greenwich, 5 patients; McCook Hospital, Hartford, 20 patients; Lawrence-Memorial Hospital, New London, 6 patients; total, 70 patients.

In addition to the patients in temporary quarters awaiting sanatorium care, there are 292 patients with tuberculosis isolated in the mental hospitals.

The Veterans Administration Hospital at Rocky Hill can accommodate 27 patients with tuberculosis on a temporary basis for transfer to veterans facilities or State sanatoria. (Now have 6 patients.) The Veterans Administration Hospital in Newington has a maximum of 20 beds for tuberculosis veterans (filled at the present time) drawn from either in or out-of-state under treatment or for transfer. It is understood that an additional 400 beds for tuberculous veterans are in process of being constructed at the William Wirt Winchester Hospital in West Haven. It is expected they will draw their patients from several states, including an unknown number from Connecticut. It is not known how many veterans at present in sanatoria in this State will be transferred to the new facilities.

NEWS FROM WASHINGTON

Cut in VA Budget Raises Furor

Several organizations are striving for reconsideration of the recent action by the House in slashing VA's budget for next fiscal year. In the forefront is the American Legion. With the cut in the budget Administrator Gray says that 22 existing hospitals will have to be closed and $4,044,550 must be sliced from the "home town" medical and dental care program. The hospitals involved are 14 general, five tuberculosis and four neuropsychiatric.

The professional personnel now utilized by VA are divided as follows: Full-time physician personnel totals 2,949, of whom 2,250 are assigned to bed service. Residents, interns and other regular part-time medical aid number 2,323 individuals. Physicians in consultant and attending capacities total 4,062. Considering all types of hospitals together, there are 30.8 beds per full time physician; ratios are 18.6 in general hospitals, 35.4 in tuberculosis and 78.3 in neuropsychiatric. During six months period ended in December, 1951, average number of patients cared for monthly was 143,000—81,700 in general hospitals, 51,500 in NP and 9,800 in TB.

Connecticut Represented on New Hospital Services Committee

With Oliver G. Pratt, director of Rhode Island Hospital, serving as chairman, newly formed subcommittee on hospital services of Health Resources Advisory (Rusk) Committee will be composed of following: Mrs. Anna Friend, assistant to director of American Hospital Association; Miss Marian Wright, R.N., assistant director of Harper Hospital, Detroit; Miss Mary Brackett, Hartford Hospital (Conn.) director of nursing services, and Rev. John J. Flanagan, S.J., executive director of Catholic Hospital Association. Ex officio members will be Mrs. Ruth Kuehn, University of Pittsburgh nursing dean, and Dr. Edwin L. Crosby, director of Johns Hopkins Hospital. Group's responsibility will be to analyze and coordinate for distribution all available information on modification of nurses' assignments, increased dependence on sub-professional workers and other expedients whose principal objective is to stretch supply of professional nurses without decreasing quality of patient care.

Oregon Case Decision Good News to Medical Societies

Supreme Court decision recently completely clearing Oregon State Medical Society and co-defendants of monopolistic practice charges will come as good news to many other state and local medical associations as well. Both before and since initiation of Oregon antitrust case by Department of Justice three years ago, records and documents of numerous affiliates of AMA have been examined by FBI agents, ostensibly in search of evidence to support other court actions under Sherman Act. However, it would now seem unlikely that government will start any more. For not only did the Supreme Court's 7-to-1 decision emphatically reject the government's case but, even more important, working relations between organized medicine and independent, consumer-sponsored clinics and health plans have practically achieved entente cordiale status in recent years.

Most recent example is Beckham County (Oklahoma) Medical Society and Dr. Michael Shadid's Community Hospital-Clinic at Elk City. Ending a two-year-old court action filed by hospital, the society has agreed to accept into membership staff members of the country's oldest cooperative hospital.

Culled From Court Decision

Justice Robert Jackson delivered opinion in Oregon case. Sole dissenter was Justice Hugo Black, with Justice Tom Clark taking no part in consideration or decision. Excerpts from the opinion: "We find not the slightest reason to doubt the genuineness, good faith or permanence of the changed attitude and strategy of these defendant-appellees which took place in 1941 . . . we agree with the trial court that conduct discontinued in 1941 does not warrant the issuance of an injunction in 1949 . . . the case derived its coloration and support almost entirely from the abandoned practices . . . appellees' evidence to disprove conspiracy is not conclusive, is necessarily largely negative, but it is too persuasive for us to say it was clear error to accept it."

Government's contentions were "plausibly and earnestly argued," says the written opinion, but they simply did not prove error in the trial court's findings. Note: Supreme Court reminded that its affirmance of lower court is "without prejudice to future suit if practices in conduct of the Oregon Physicians' Service or the county services, whether or not involved in the present action, shall threaten or constitute violation of the antitrust laws."

$483 Million Pledged by U. S. to Hospitals

Hill-Burton hospital construction summary for the end of March gives the total federal contribution to all projects, (completed, in operation, under construction or only initially approved) at $483 million with the final cost–federal and local–set at $1,353 million. In all 1,773 projects (85,012 beds) have been processed since start of the H-B program. Below is a summary of the status of all construction:

TOTAL PROJECTS	TOTAL COST	FEDERAL COST	BEDS ADDED
Completed 850	$440,643,376	$141,390,874	29,969
Under construction....762	762,544,996	286,654,490	46,573
Initially approved 161	149,559,082	55,028,800	8,470

Action by Congress

S2731—To authorize transfer of hospitals and related facilities between the Veterans Administration and the Department of Defense. The Senate Committee on Labor and Public Welfare April 24 favorably reported this bill. At the present time the military services are authorized to transfer without reimbursement such facilities to the Veterans Administration but the VA is not accorded the same privilege. This bill would permit reciprocity.

S3019—Special pay for military physicians and dentists. A subcommittee of the Senate Armed Services Committee in executive session April 28 favorably reported this bill without amendment to the full Armed Services Committee. Prior to the closed door session of the Committee additional testimony was heard from Melvin Casberg, M.D., chairman of the Armed Forces Medical Policy Council; Major General George E. Armstrong and Rear Admiral H. L. Pugh, Surgeons General of the Army and Navy, respectively, all testifying in favor of the bills provisions.

Public Law 139 (formerly S349)—Defense Housing and Community Facilities and Services Act of 1951. April 22 the Senate passed the third supplemental appropriation bill HR6947. The bill, among other things, authorizes a 4 million dollar appropriation to remain available until June 30, 1953, for the Federal Security Agency to carry out its part in assisting communities with facilities and services in crowded defense areas. This amount is the same figure recommended by the House of Representatives. The FSA had appealed to the Senate Appropriations Committee to increase this amount but failed to convince either the Committee or the Senate membership.

Houses Passes Bill Favoring Physicians and Other Skilled Immigrant Applicants

The House April 25 passed a bill drastically revising the Nation's immigration laws. The bill (HR5678) introduces a high degree of "selectivity" in choosing between applicant immigrants. The first 50 per cent of the quota of each country annually would be made available to qualified quota immigrants whose services are determined by the Attorney General to be needed urgently in the United States because of the high education, specialized experience, or exceptional ability of such immigrants, and to be substantially beneficial to the national economy, cultural interests, or welfare of the United States. This group of skilled persons (including physicians) and their families would be given preference over alien parents of citizens of the United States and qualified quota immigrants who are spouses or children of aliens lawfully admitted for permanent residence in the United States. Unfilled quotas from other than the skilled person group could also be used to admit persons in the skilled category.

Skilled persons, including physicians, would be admitted only after a petition had been filed with the Attorney General by "any person, institution, firm, organization, or governmental agency desiring to have an alien classified as an immigrant . . ." under the proposed new section of the laws. The petition shall state the basis for the need of the services of such alien and other such additional information and be supported by such documentary evidence as may be required by the Attorney General. The bill provides that the Attorney General shall investi-

gate the facts and consult with appropriate agencies of the government before making a determination.

The bill prescribes only a general formula based on population to determine the annual quota for each country. However, the Visa Division of the State Department prepared a table which indicates that 154,657 immigrants would be permitted immigration visas annually. The quotas of several countries are as follows: Great Britain and Northern Ireland, 65,361; Germany, 25,814; Ireland, 17,756; France, 3,069; Poland, 6,488; Spain, 250; Italy, 5,645; and the Netherlands, 3,136. Quotas of 100 annually are allowed many counties including Burma, Cambodia, Ceylon, Indonesia, Korea, Laos, Libya, Pakistan, Somaliland, Vietnam, and Yemen.

The Senate companion bill, known as S2550, has been reported by the Committee and has been placed on the Senate calendar for possible debate on the floor very soon. The Senate provision regarding skilled persons, including physicians, is identical with language of the House bill.

Murray and Dingell Introduce Bills for Hospitalization at Age 65

Senator Murray and Rep. Dingell have introduced identical bills to authorize establishment of a system of government paid hospitalization for everyone eligible for social security benefits. Eligibles would include persons 65 and over who are covered by social security and their dependents as well as the survivors of deceased persons so insured. Hospital benefits would be limited to 60 days in any one calendar year.

Some of the provisions: 1. Beneficiaries would be eligible for drugs, services and appliances "customarily furnished by such hospital to its bed patients," but tuberculosis or mental hospitals "or any hospital or institution which furnished primarily domiciliary or nursing care" could not participate in the program. 2. A physician would have to determine that hospitalization was required. 3. Although costs would be paid out of the Social Security Trust Fund, state departments of health would handle details. The states could, if they so decided, turn administration over to Blue Cross or other nonprofit insurance organizations.

In a statement, Senator Murray and Rep. Dingell said about seven million persons would be eligible. They estimated the cost at $200 million annually.

Mindful that their bill will be opposed by AMA, Murray and Dingell nevertheless are fishing for rank and file support among practitioners when they say their plan would be a boon not only to the indigent, state and local governments and budget harassed hospitals but to physicians as well. "Doctors will be free to recommend hospitalization for their elderly patients on the basis of their own medical judgment and without having to worry about whether or not the patient can afford to pay the hospital bill," they said. "The doctor will also stand a much better chance to collect his own bills promptly and in full once the hospital bill, biggest item in medical care costs, is out of the way."

70 Per Cent of Federal Civil Defense Funds Go for Medical Purposes

Approximately 70 per cent of all federal money spent on civil defense is going for medical purposes, principally matching grants to states for local medical stockpiling and all-federal regional stockpiles. This breakdown of Federal Civil Defense Administration activities is contained in Administrator Millard Caldwell's annual report, covering the first full year's operations of FCDA. So far FCDA appropriations for all purposes have totaled about $100 million. Of this, $50 million is earmarked for all-federal medical purchases. $20 million will be used either for federal medical purchases or matching grants to states.

New Hampshire Physician Named to Magnuson Commission

Dr. Donald M. Clark, 51, of Peterborough, N. H., has been named by President Truman to the Commission on the Health Needs of the Nation, filling the vacancy left when AMA Trustee Gunnar Gundersen declined to serve. Dr. Clark participated only recently in a panel discussion of the commission on general practice. He received his medical degree from the University of Vermont College of Medicine (1926), and is a member of the American College of Surgeons and the New England Surgical Society and is a fellow of the American Medical Association.

Pharmaceutical House Found Guilty

Office of Price Stabilization's first action against a pharmaceutical house involves a Buffalo, N. Y., wholesale mail order firm charged with selling at over the ceiling prices. OPS seeks $150,000 in treble damages.

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Latest Data Presented on Doctor-Draft Registrants

Compilation by Selective Service headquarters of information transmitted by the various states on status of physicians subject to conscription are condensed as follows: Priority I—10,835 living registrants (16 are deceased), of whom 10,802 have been classified for draft purposes. In major categories, 1,101 are in 1-A and acceptable; 3,307 are on active military duty (1-C); 2,394 are inactive Reserves; 1,497 hold essentiality deferments, and 2,125 are in 4-F. Priority II—2,544 living registrants (two are deceased), of whom 2,504 have been classified. Of this number, 535 are in 1-A and acceptable; 273 are in uniform; 481 are Reserve members; 595 are deferred as 2-A's, and 415 are 4-F's.

Army Selects Students for Intern Program

Appointment of 146 senior medical students for the Military Intern Program of the Army Medical Service was announced recently by Major General George E. Armstrong, Army Surgeon General.

The Program, scheduled to get under way July 1, provides that medical students, upon graduation, can be commissioned as first lieutenant in the Medical Corps Reserve and serve their internships in Army hospitals.

Representing 51 medical schools and colleges, the students will be assigned to the ten Army teaching hospitals in the United States and to Tripler Army Hospital in Hawaii. Ninety-eight of those selected, including the three women in the group, have previously served in the armed forces.

In applying, each student was allowed to indicate three hospitals, in order of preference, in which he desired to receive his internship. General Armstrong stated that 75 per cent of the students have been assigned to the first hospital of their choice.

There will be 19 students assigned to Fitzsimmons Army Hospital, Denver, Colorado; 23 to Brooke Army Hospital, Fort Sam Houston, Texas; 13 to William Beaumont Army Hospital, Fort Bliss, Texas; 17 to Letterman Army Hospital, San Francisco, California; 24 to Walter Reed Army Hospital, Washington, D. C.; 16 to Tripler Army Hospital, Hawaii; 8 to Valley Forge Army Hospital, Phoenixville, Pennsylvania; 5 to Army and Navy Hospital, Hot Springs National Park, Arkansas; 13 to Madigan Army Hospital, Tacoma, Washington; 4 to Percy Jones Army Hospital, Battle Creek, Michigan; and 4 to Murphy Army Hospital, Waltham, Mass.

Connecticut will be represented by John D. Haugh of Norwalk, assigned to Murphy Army Hospital, Waltham, Mass.

War Manpower Council Urges Military Deferment Through One Year of Residency

The War Manpower Council, a citizens' organization financed by the Ford Foundation, has recommended that physicians be deferred from military service until completion of one year of residency training. The Council's report, Student Deferment and National Policy, lists this among its 14 recommendations made to Defense Department, Selective Service and other government agencies.

Currently, medical students are deferred through one year of internship, by which time they are subject to the Doctor-Draft law.

The Council also suggested that: (a) deferment of young fathers be ended, (b) present student deferment on the basis of aptitude tests and class standing be continued, (c) the military make the best possible use of its own scientific and technical personnel by turning many jobs over to civilians and (d) the military check into its procurement policy to see if it is using too great a proportion of scientific and engineering school graduates as line officers.

Neither Defense Department nor Selective Service has commented on the recommendations but both are studying the proposals.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1951 - 1952 (Concluded)

REPORT OF THE CHAIRMAN OF THE COUNCIL

The Council continues to meet at regular intervals with excellent attendance by both Councilors and Alternates.

Since a report of the activities of the Council is presented at each of the County meetings, it seems hardly necessary at this time to review these actions in detail.

You will recall that the Council voted to appropriate five thousand dollars for the Educational Fund of the American Medical Association. This action was rescinded after an explanation of Dr. Murdock, trustee of the American Medical Association, and after further study it was deemed more advisable to make a contribution of one thousand dollars this year and observe the progress of the plan each year thereafter.

One of the most progressive steps taken by the Council and the House of Delegates was the approval of the election of a Speaker and Vice-Speaker of the House. As our Society expands, it seems quite necessary that the President be relieved of the duties as acting Speaker, and that some person familiar with parliamentary procedure be elected to hold office for longer than one year. The Nominating Committee today will present to you the names of a Speaker and Vice-Speaker for your approval.

For the first time in the history of any State Medical Society you have been offered group insurance against catastrophic illness. The executive secretary, working with the insurance company, has developed a plan which is unique and which should appeal to practically all of our members. You have received communications regarding this insurance, and although the number first specified by the insurance company has not been reached, nevertheless, with the approval of the Insurance Commissioner, the plan is now in force.

For some years it has been the custom to publish in our STATE JOURNAL the verbatim minutes of our House of Delegates. Frequently there were confidential matters which should not have been published, and some criticism has arisen from far distant States regarding actions of the House. It was voted by the Council that the executive secretary and the editors of the JOURNAL shall edit these minutes before publication.

A short time ago a Committee was appointed to consider the possibility of an addition to our present State Society building. The Connecticut Medical Service, now occupying the building on Whitney Avenue with Blue Cross, is rather cramped in its quarters, and as it expands it will be necessary to have additional space. There is a possibility, therefore, that an addition to our building might make a suitable home for Connecticut Medical Service. This is in the stage of study and nothing specific has been decided.

A number of letters have come to the Council regarding certain activities of the Welfare Department, and during the year a special Committee was appointed to make a study of the State Welfare Department as it relates to the physicians of our Society. A preliminary report will be made later in the day.

The Clinical Congress for the past few years has had a marked falling off in attendance, and because of some concern by the Council, Dr. Thoms and Dr. Bishop were appointed as a special committee to make a study of this problem. Their recommendations as presented to the Council a short time ago were as follows:

1. That the Clinical Congress be continued for at least one more year.

2. That the entire Congress be held under one roof, i.e., New Haven Hospital.

3. That the sessions be reduced from three to two days.

4. That the program consist of symposia and panel discussions instead of formal papers.

5. That the fee be reduced to three dollars for members and five dollars for those outside the State.

For the past few years we have been urging the various County Societies to present the names of those whom they would consider suitable and anxious to work on various Committees of the State Society. Until this year we have had little response to these requests, but just before the Nominating Committee met this winter, we had responses from practically every County with long lists of names. It was not possible to place each of these individuals on a committee since it requires some experienced people to steer the committee along the proper channels. However, many of these nominees were placed on committees, and we hope that the Counties will not be discouraged because all were not utilized. We would urge you to continue this plan of submitting the names of willing workers each year to the Nominating Committee.

In closing may I thank the Councilors and Alternates for their attendance and enthusiastic discussion of so many important points brought before the Council; Dr. Creighton Barker, our executive secretary whose clear thinking and guidance makes it possible for not only the Council, but the entire Society, to proceed with dispatch and whose experience over the past several years both in our own office and through national contacts has brought to the Council mature judgment which frequently solved difficult problems within a short time; and the loyal office staff of our building deserves great credit for they, although in the background, are a great factor in the success of our Society.

We are expanding rapidly and it will take cooperation between the Counties and the State Society to carry on as

efficiently as we have in the past. I would urge you, therefore, to become interested in the various activities of your Society so that we may continue to be one of the leading State organizations in the country.

Thank you.

Respectfully submitted,
Joseph H. Howard

REPORT OF THE PRESIDENT

A report of the President should by definition be a formal, or official, account of the activities of this Society. This seems like an overwhelming task, and certainly a needless one, when the number of the activities, if numbers alone are to be considered, of this constantly growing, and certainly active, Medical Society.

As you well know, our Society conducts most of its affairs in a whole series of Committees, which, each in its own sphere, concerns itself with the different aspects of medical practice, and particularly medical affairs outside of practice. So, when situations or facts are studied and their usefulness or not are determined and decisions, or recommendations, are arrived at by the Committees, they usually funnel their results into the Council. The Council either carries it then to a decision or brings the matter to the attention of this House of Delegates. The functions of the Council are so carefully reported by our JOURNAL that the members of this Society may be well informed at monthly intervals throughout the year. A perusal of the agenda for this meeting readily gives one a concept of the number of committees active in our Society and as one reads the reports of these different committees he cannot but be impressed with the extent and the amount of work that these groups are performing and the amount and extent of the endeavor and the high quality of the work. Certainly in these reports there are more complete, and, shall I say, better expressed accounts of the activities of this Society than any single report such as might be attempted here could be. However, I believe it is appropriate to stress some aspects of a few of the current problems and so would like to draw attention briefly to a few features that I believe are particularly important, or are of special interest to me personally.

I feel that the present policy of placing more of the younger men on committees will prove to be a fruitful one. As the Councilor from each of the Counties comes to the task of nominating members to the different committees, the names of new, or beginning-to-be-established physicians, especially if a local canvass shows a preferred interest, will result with every member of the Society, as far as practicality will permit, eventually having a job in the Society. Thus, as the younger physician progresses, he should not be interested only in the development of his own practice but, having a task to perform for his Society, and so feeling to be part of it, he will, as he grows, along with his interest in his medical practice, have as much interest in the affairs of his Medical Society.

The problem of Physician Relationship with Hospitals, specificially the relationship of the sections on Anesthesiology, Pathology, and Radiology, and their relationship with the hospital, and particularly in regard to their either full or part time employment by the hospital, is still a problem. The particular question of the collection of fees and the payment of salaries, and other similar features of the problem are still vexing and complicated ones. The AMA has taken a stand on this matter in middle ground, with the perhaps more aggresive Hess report having been subjected to a second or third look, put back, at least for the time being, into the files. And a restatement of policy returns the problem to a local status. The mechanism of how to handle the inability to act of the appropriate County committees when either someone else interested, or the physician involved, brings up the question of the proper ethics of his conduct, is now outlined. However, most physicians, I am afraid, do not feel that the matter has as yet been crystalized and feel that some sort of a precipitant is still necessary to be added before clarity can be reached. Much well informed study and clear thinking must be brought to bear on this subject. No easy solution or formula at present has appeared.

The opinion of this House and of this Society has been often enough expressed so that there is no doubt regarding its stand alongside that of the AMA in the opinion against Compulsory Insurance and other schemes of Federal control of the practice of medicine. For this Society through a number of years has given a great deal of time and study to the problem of how to offer a better solution than that of the Federal planners. A solution medically better for the patient, ethically better for the physician, and one which both the patient and, so, the country can reasonably afford to pay for.

This Society eventually brought out its own plan: Connecticut Medical Service. And not having, as it were, been in the business before, has found it not to be perfect in all respects. It has been astounding, however, how well it has worked and two comments can be made. First, it supplies a great need—one that must have been obviously there but was in greater demand than realized. And secondly, the enrollment in it is already so large that if it is properly cultivated there appears to be no good reason at present why it cannot enroll all employed citizens in this State. If this can be made to be so then it has all the appearance of a bulwark against further immediate inroads into medical practice by our Federal government. We know that CMS is not adequate in all respects and does not give as sufficient coverage as we would ideally wish for. It must advance further into fuller coverage and into wider physician participatoin, and must eventually include medical inhospital benefits, some reasonable form of a catastrophic feature, and indeed perhaps even some type of liberalization for home care of general medical cases. It must do all that and yet in its cost not get beyond the level to which the low and moderate income groups, for which the service was really devised, can pay for. And when I say pay for, I mean to continue to pay for through ordinary economic vicissitudes as well as during artificial boom times, so that there may be no forseeable situation arise where Federal taxation can be made an entering wedge.

In spite of the current success of CMS we must not allow ourselves to become complaisant in these policies, for

it is only necessary to read the purposes for which the President set up his recent Commitee to Study the Health Needs of the Nation and to read his comments regarding his reasons for creating this group, to become perturbed again by his intentions. This is the group from which one of the Trustees of the AMA felt compelled to immediately resign as soon as he saw the intent of the project.

For these reasons I believe that the proposal of the Professional Policy Committee of CMS, which will be brought before this House today, is important, for it makes an advance toward the more complete objective of Voluntary Prepaid Health Insurance. It offers, only in a modest fashion initially, a further coverage in a sphere that is still lacking coverage and it brings into the Doctors' Plan, doctors who heretofore have had no opportunity to function within the plan nor receive benefits from it. Personally I hope this House will see fit to approve the proposal of the Professional Policy Committee of the CMS.

Some months ago I drew attention in our JOURNAL to one aspect of the responsibility of the physician when the physician-patient relationship starts with the acceptance of a patient for treatment, and especially the treatment of trauma. One of the responsibilities includes the need to protect the patient's interests if the trauma was caused by accident of the type related to casualty, negligence on the part of others, incidents under Workmen's Compensation Law, or similar controversial situations. As was pointed out these features of medical practice often bring the physician into contact with another profession—the law. Not infrequently, bad public relations, and particularly bad medicolegal relations result because of failure perhaps on the part of both professions to understand the problems of the other, to appreciate the limitations and the interests of the other, and to work in cooperation for the mutual benefit of the patient.

At that time a suggestion was made that a committee from the different County Bar and County Medical Associations might be created and on a County level rather than at a State, because the largest number of cases are treated medically and then are tried legally in the local courts so that the contacts are usually a local problem. This suggestion has been followed in one County, and such committees have had individual and then combined meetings. And now there is to be a unique meeting—the outcome of the previous ones—a combined meeting of both the County Bar and the County Medical Associations. At this meeting a panel of a few doctors and a corresponding number of lawyers and led by a judge of the Superior Court, will attempt to discuss mutual grievances and interests, and complaints and questions from the floor.

No visible harm can seemingly come from such a project. And it may well awaken doctors to both the patients' rights and the lawyers' problems, and vice-versa. Certainly the patient will get a more knowledgeful medical and legal management, even if no one else were to gain.

This movement, though it appears to have been spontaneous, and to have arisen without evident relationship to the activities of our Committee on Expert Medical Testimony, headed by Dr. Louis H. Cohen, is really the work of a legal protagonist. He was on intimate terms of friendship with certain medical persons in that locality and being unusually aware of the problem, through several years has brought much effort to the attempt to better a situation which at times has not been a happy or dignified one from either the medical or the legal point of view. It will be interesting to watch this situation develop and to see whether it will bear fruit in the future.

Another project which for the first time has been issued to a medical group, this Society, previously having been available only to certain high income executives, is the new catastrophic health insurance, now available to our members by the same insurance company that has carried the blanket policy for health and accident insurance for this Society. This also will be an interesting experiment to watch through the coming years. For from its experience probably some features can be utilized in one fashion or another for the purposes of broadening still further the coverage of CMS.

And finally having been in fairly intimate contact with it for the past year, may I express the opinion that the structure of this Society is sound, its foundation firm, its objectives are reasonably clear and commendable and, I believe, as long as the quality of the officers continues at its present high level, your Society is safe and likely to continue in an honourable existence performing useful functions both for the citizenry and the medical profession of the State of Connecticut.

Respectfully submitted,
Brae Rafferty

REPORT OF THE TREASURER

The Auditors' Report detailing the financial activities of your Society during the fiscal year of 1951 appears on pages 27 through 31 of the Agenda for this meeting. According to an attached statement by the Auditors "the balance sheet and statements of income and surplus present fairly the position of the Connecticut State Medical Society at December 31, 1951, and the results of its operations for the year, in conformity with generally accepted accounting principles . . ."

Although the figures presented by the Auditors are comprehensive and detailed, it seems proper, if the House of Delegates will allow the time, to discuss and examine certain phases of the past year's financial operations.

The budget for 1951 was prepared by a committee from the Council, consisting of two elected County Councilors and the Chairman of the Council. This budget adopted by the House of Delegates on November 29, 1950 was based upon an estimated gross income of $87,400. Actual gross income was $93,358.84. This figure is obtained by adding the income from the Society operations proper to income produced by the JOURNAL. Estimated operating expenses for the 1951 budget were set at $85,265.32, thus contemplating expenditures of $2,134.68 less than anticipated income. Actual expenditures amounted to $85,119.73, or $145.59 less than budgeted. However, since the actual gross income amounted to $93,358.84 there was a net operating income at year's end of $8,039.52 to be added to the General Fund Surplus.

With the addition of the 1951 net income the General Fund Surplus on December 31, 1951 was $74,522.01. On the same date the surplus in the Annual Meeting Fund was $13,232.34 (including $2,952.29 prepayment toward the 1952 Annual Meeting). Surplus in the Clinical Congress Fund was $3,430.14. These three items comprise earned Surplus Funds totalling $91,184.49 which is an increase of $8,545.52 since January 1, 1951.

In addition to the General Fund Surplus, equities in the Russell Fund, the O. C. Smith Fund, residue cash in the Building Fund, and the Reserve Fund for Building Depreciation amount to $15,142.95.

Your Society through gifts from its members owns unencumbered real estate and equipment valued at $89,005.62. Thus, on December 31, 1951 the financial worth of the Society was $195,581.19, or an increase of $10,797.92 for the year.

The basic source of financial support of the Society derives from dues paid by its members. The budget included an estimated income from dues of $60,000. This figure was arrived at by multiplying the number of active members by the amount of established dues, and then depreciated by $2,500 to allow for dues exemptions of members entering the military service. Actual dues income exceeded estimates and amounted to $63,521.50, less $275.45 paid in commissions to County Secretaries, or a net of $63,246.05. It is gratifying to record once again the splendid cooperation of the membership in their prompt attention to the payment of dues. It is noteworthy that only infrequently is it necessary to drop a member for nonpayment.

Year to year comparison of budget estimates of expenses with actual expenditures is always interesting, and practically always expenditures closely adhere to or remain well within these estimates. During 1951 the Secretary's office under expended its budget by $1,423.96, the Treasurer's office by $78.26, Public Relations by $144.68, Committee Allotments by $1,041.38, or a total of unexpended budget of $2,688.28. Budget estimates for General and Contingent Expenses were over expended by $753.04, for Building Expenses by $373.26 and the JOURNAL by $1,416.39, or a total of over expenditures of $2,542.69 with a net of $145.59 less expended than was budgeted, as previously noted.

The estimate for General and Contingent Expenses was over expended by $753.04 due to unanticipated additional expense of delegates to AMA because of a change in the location of the semi-annual meeting.

The over expenditure under Building Maintenance was due principally to two items: $180.79 for electricity, gas and water, and $173.05 for care of grounds, in excess of budget estimates.

Over expenditure in the JOURNAL account was due largely to the item of manufacturing cost which was $987 higher than estimated.

As noted on page 30, Building Operation Expense amounted to $6,623.26. However, included in this figure is the sum of $1,400 which is transferred yearly to a special savings account (see page 28, line 29) as a cash interest earning reserve for depreciation and obsolescence. Thus the actual cost of operating the building for occupancy in 1951 was $5,223.26. Rental income from space leased to the Connecticut Medical Examining Board, the Connecticut Hospital Association, and the Selective Service System Advisory Committee amounted to $2,280. Thus the net cost to the Society for operating and occupying its own building was $2,943.26. It is hardly likely that the space and efficiency of our working quarters could be duplicated at such an outlay for rental elsewhere.

The financial statement of the JOURNAL reflects a favorable trend, and the time when once again it may be a self supporting and profitable enterprise may not be far distant. Although expenses in 1951 were greater than the previous year by $2,564.99, largely due to higher manufacturing costs, income for 1951 was better by $3,871.33. Therefore, while excess of expenses over income was $6,553.89, actually this amount was $1,306.34 more favorable than in 1950. Thus during 1951 each member who paid $25 dues contributed 18 cents per copy for his JOURNAL.

It should be borne in mind that the Annual Meeting bears no cost to the membership. Income for the Annual Meeting Fund derives from fees paid by exhibitors. As noted on page 30, the excess of income over expenses for the last annual meeting was $1,501.49. Cash surplus including interest on December 31, 1951 amounted to $10,208.05; and in addition, $2,952.29 had already been paid toward the 1952 meeting to make a total surplus of $13,232.34.

The Clinical Congress Fund derives its income from registration fees. Again, as in two previous years, expenses exceeded income, this past year by $200.58. Surplus in this fund now stands at $3,430.14 or $132.38 less than last year. As members of the House are aware, a committee is now engaged in the study of the Congress and will, no doubt, submit helpful recommendations.

Once more it is my honor and privilege to report that the statement of the auditor indicates that the financial affairs of our Society are in good order. The reasons for this are several. The membership by its loyal support makes the financial operations possible. The Council as the Finance Committee of the Society exercises judgment, thrift, and close attention to the best interests of the Society and its finances. Our fiscal agent, the Second National Bank of New Haven, handles receipts and disbursements with a highly efficient system of vouchers and controls. Our auditors, Seward and Monde make careful monthly audits and a complete detailed summary for yearly submission to the House of Delegates. Theirs is an efficient and careful service.

In our own office, Mrs. Josephine Lindquist has long demonstrated her efficiency and her devotion to the interests of the Society. She is responsible for accounting, records, billings, preparation of periodic reports and the affairs of the treasurer's office, and she is capably assisted by Mrs. Mary Reilly Duffy. I repeat that the Society is fortunate to enjoy the able and loyal service rendered by these young women.

And as in all of its affairs the Society has the judgment and wise counsel of its executive secretary in all fiscal matters. As treasurer I should like to make acknowledgment to all those I have enumerated and to express my

sincere thanks for their loyal, helpful and continuing cooperation.

Respectfully submitted,
Cole B. Gibson

REPORT OF THE PROFESSIONAL POLICY COMMITTEE

Thomas J. Danaher, *Chairman*

Henry A. Archambault
William Curley, Jr.
Thomas Feeney
Norman C. Margolius
Louis F. Middlebrook
Denis S. O'Connor
Walter I. Russell
Edward H. Truex, Jr.
William H. Horton

The activities of Connecticut Medical Service were last reported to the House of Delegates at the Annual Meeting in May 1951. At that time the amended contract had just become effective. The experience during this year indicates that the more realistic income level for service benefits, the readjusted surgical fees and the expanded fee schedule have been well received by both the subscribers and the participating physicians.

The routine work of the Professional Policy Committee has been relieved somewhat during the year but there still are many procedures in the "individual consideration" and "operations not listed" groups. Administrative policies have been established for some of these procedures throughout the year.

The House of Delegates of the Connecticut State Medical Society at its annual meeting in May 1951 passed resolutions to the effect that physicians practicing anesthesiology and radiology should be privileged to practice on a fee basis as are other physicians in the state of Connecticut. Therefore, the Professional Policy Committee has given some thought as to how these services could be prepaid by Connecticut Medical Service.

Several meetings have been held between the subcommittee of the Professional Policy Committee and the representatives of anesthesiology and radiology. It is not the intention of Connecticut Medical Service to decide whether these services should be rendered as a hospital or a private professional service, but either Connecticut Medical Service or Blue Cross can provide coverage of these services when the physicians concerned determine how they wish to have these services provided.

Up to the present time, neither group of physicians practicing anesthesiology or radiology has notified Connecticut Medical Service that they have reached any definite conclusion regarding their type of practice.

In view of the change in the Enabling Act whereby Connecticut Medical Service can pay for service rendered by dental surgeons, it was necessary to approve certain procedures in the schedule for payment as dental surgery. These changes have been published in the Physicians' Bulletin.

During the past year Connecticut Medical Service has been offered to the direct-payment members of Connecticut Hospital Service. The result of this offering has been gratifying as 55,000 members elected to become subscribers of Connecticut Medical Service.

In spite of the slight loss of membership a year ago, due to the increased premium of the amended contract, Connecticut Medical Service has continued to grow, so that at this time, we have approximately 500,000 members.

At the present time we have 1,801 participating physicians—this is 96 per cent of all Connecticut physicians whose practice includes services covered by the present contract. The cooperative attitude of our participating physicians continues to be the great contribution to the success of Connecticut Medical Service during this year.

During the past year claims have been paid at a rate of over a thousand a week, 97 per cent of these claims are paid within 72 hours and 3 per cent have been referred to the Professional Policy Committee.

You will note in the Annual Report published in the CONNECTICUT STATE MEDICAL JOURNAL that Connecticut Medical Service is financially sound. Net premium earnings were over $4,000,000; $3,000,000 was paid out for surgical and obstetrical care; 9.1 per cent of the premium earnings was used for operating expenses; there was a reserve for contingencies on December 31 of approximately $725,000.

During the past three years many Connecticut physicians have stated that inhospital medical care benefits should be provided for subscribers of Connecticut Medical Service. In view of the good financial position of Connecticut Medical Service on January 1, 1952, it seemed advisable to consider providing this type of benefit for the subscribers at this time.

Early in the consideration of this project, it was evident to all that there should be no increase in premium at this time. As medical care benefits were to be limited to hospitalized subscribers, it was necessary to plan the benefits in such a way that there would be a minimum of increase in hospital occupancy by the subscribers of Connecticut Medical Service.

The plan as proposed is conservative both as to benefit for the subscribers and remuneration for physicians. As experience is gained with this type of plan, greater benefits to subscribers and physicians can be provided as has been done in the past with surgical and obstetrical contracts. The proposed program is as complete as can possibly be offered at this time, and it appears wise to take this step now rather than to wait another year or so in order to offer a more complete program.

PROPOSED PROGRAM FOR INHOSPITAL MEDICAL CARE BENEFITS

March 18, 1952

The Board of Directors of Connecticut Medical Service, Inc. has, subject to acceptance by the House of Delegates of the Connecticut State Medical Society, authorized payment of additional benefits for the professional services of Doctors of Medicine (M.D.), rendered in a hospital for the treatment of medical (non-surgical) diseases, *without any increase in premium*, until the next annual meeting of the Board of Directors on March 17, 1953.

THESE ADDITIONAL BENEFITS ARE:

1. Payment at the rate of $3.00 for each day the physician visits a patient while he is hospitalized, for the treatment of any medical (non-surgical) condition beginning on the

fourth day of *each* hospital admission and continuing thereafter, not to exceed a total of 21 payable days during 1952.

2. If the doctor is a Participating Physician in CMS, payment will be made directly to him and the patient will be notified.

3. If the doctor is a Non Participating Physician in CMS, payment will be made directly to the patient.

4. Service Benefits will apply to all patients who are eligible (as with the surgical-obstetrical contract) for the period of hospitalization covered by CMS, as outlined in paragraph (1) above.

LIMITATION OF THESE BENEFITS

1. The doctor's charges during the first three days of hospitalization will be at whatever rate he feels is reasonable for the professional services he renders. Since in the majority of illnesses requiring hospitalization, the greater part of the diagnostic "work-up" or intensive treatment takes place during the first days of hospitalization, it is to be expected that the doctor's charges for the first three days will usually be greater than the rate paid thereafter by CMS.

2. The rate paid by CMS is not intended to indicate in any manner the charge which the physician may make for his services during the three days before CMS coverage begins.

3. The patient-member is personally, financially responsible to the doctor for all of his charges for the first three days, without reference to any payments which may be made by CMS for his services thereafter.

4. If the patient is entitled to Service Benefits, the payment by CMS for the day-visit on the fourth day and thereafter, will be accepted by the Participating Physician as his total charge for each day he visits during the period of CMS coverage. The Service Benefit patient, however, will still be responsible for the Participating Physician's charges for the first three days.

5. When the patient is *not* entitled to Service Benefits, the same amount of payment will be made as a Contract Allowance, but (as with the surgical-obstetrical contract) the Participating Physician may make such additional charges as he feels are reasonable.

6. All payments for the services of Non participating Physicians will be made directly to the patient as Contract Allowances.

7. Benefits are available only when the patient is hospitalized in a licensed general hospital.

NO BENEFITS (INHOSPITAL MEDICAL CARE) ARE PROVIDED:

a. During the same uninterrupted hospital stay in which a surgical operation for which CMS is liable for payment is performed.

b. During the same uninterrupted hospital stay during which a maternity delivery is performed.

c. Hospital care of the newborn. (They are not members of CMS until an application has been made and accepted as required by the enrollment regulations.)

Note: The Board of Directors reserves its right to modify these additional benefits, should it be deemed necessary to do so, before the next annual meeting.

COMMENT ON INHOSPITAL MEDICAL CARE BENEFITS—CMS

The actuarial study for additional inhospital medical care benefits by Connecticut Medical Service was based on the utilization of hospital service by Blue Cross subscribers for medically diagnosed conditions. It was found that forty per cent of Blue Cross hospital cases were discharged with a medical diagnosis; twenty per cent of these cases were discharged prior to the fourth hospital day; fifty per cent were discharged prior to the eighth hospital day.

It can be easily understood that any increase in either the number or the length of stay of these types of patients will jeopardize both Blue Cross and Connecticut Medical Service. Control of these statistics is in the hands of the physicians of Connecticut.

In view of the excellent cooperation of the participating physicians with CMS's present program, it is to be expected that physicians will not cause any increase in the utilization of hospital services on account of the inhospital medical care benefits.

However, at the time of the announcement of the increased benefits of Connecticut Medical Service, members of the House of Delegates should notify the physicians in their community that the success of the venture depends upon their cooperation.

Connecticut Medical Service is planning on May 15 to celebrate the enrollment of their 500,000th member and expects to announce the new program at that time. All members of the House are requested to keep this subject from the public until the proper announcement can be made by Connecticut Medical Service.

REPORT OF THE SPECIAL COMMITTEE TO STUDY STATE DEPARTMENT OF WELFARE MEDICAL SERVICES

At the semiannual meeting of the House of Delegates held in December of 1951 a resolution was introduced by the Eye, Ear, Nose and Throat Section pertaining to the present administrative method of treatment of State Welfare Aid cases.

A Committee was appointed consisting of Joseph H. Howard of Bridgeport, chairman, and C. L. Fincke of Stamford, Dewey Katz of Hartford, J. H. Root of Waterbury, and W. H. Upson of Suffield.

Shortly thereafter correspondence was received from pediatricians, internists, orthopedists, general practitioners, and others requesting a hearing with relation to the effect upon their practices by the rules and regulations of the State Welfare Department.

The first meeting of the Committee was held at Commissioner Smith's office in Hartford on February 6, 1952. All of the Committee members were present at this time as well as Commissioner Smith and Dr. Victor Wallace, medical director of the State Department of Welfare. The problems which the Committee presented and which they felt were undesirable to practicing physicians were as follows:

1. In following the rules of the State Department of Welfare patients were denied free choice of their physician where a specialist's care is indicated.

2. The present procedure is expensive since it duplicates medical effort.

3. A patient needing a specialist's care would be delayed, or denied this care.

There was also some discussion of the Fee Schedule and suggestions were made regarding changes.

Another matter to be considered was the question of laboratory procedures since there is no allowance made for laboratory work done in a physician's office.

The present policy of the State Welfare Department is based on a ruling of the Attorney General of July 12, 1951 and is taken from the General Statutes which reads as follows:

"A beneficiary under an Old Age Assistance award made under this chapter shall receive aid to an extent necessary to maintain a standard of living reasonably compatible with health and decency, provided in cases where said amount is insufficient to furnish necessary medical or hospital treatment to a beneficiary, the Commissioner of Welfare shall order the payment of such additional cost of medical care as he shall deem necessary and reasonable, and such additional cost of hospitalization as is provided in Section 275a and 276a."

The Attorney General continues:

"Thereafter the problem is solely one of determining whether or not a Specialist's services are necessary to dispense the treatment which is required. This represents a medical determination, to be made finally by the Commissioner of Welfare, acting upon such medical advice and counsel as he deems necessary."

A second meeting of the Committee was held at the office of the Connecticut State Medical Society on February 12, 1952, with further discussion and particular emphasis upon the Fee Schedule. At that time the Committee voted to have the Chairman communicate with Commissioner of Finance Lynch, and suggested that the original Fee Schedule Committee of 1951 be asked to confer with our Committee regarding certain portions of the Fee Schedule.

Dr. Cole Gibson was Chairman of that Fee Schedule Committee, and since he was unable to arrange a suitable date at which time all other members of his committee could be present, he suggested he make an appearance before our Committee to explain the Fee Schedule. This was done on Tuesday, April 15, 1952.

Just previous to this meeting letters were sent to various groups throughout the State requesting that they appoint a representative to appear at the April meeting. As a result there were present in addition to the regular Committee, William Reardon of the Eye, Ear, Nose and Throat Section and Peter Scafarello, Academy of General Practice.

Dr. Gibson went into detail describing the development of the Fee Schedule and explaining that it was not maintained primarily for the Welfare Department, but for all Institutions, Departments and Agencies of the State of Connecticut dealing in health services. At this meeting Doctor Wallace expressed the opinion that there may have been some misinterpretations regarding the relationship between the physicians of the State and the State Welfare Department. It was the opinion of the Committee that if there were misinterpretations, they should be clarified, and Dr. Wallace was asked to prepare a statement which would eliminate much of the criticism now aimed at the State Welfare Department.

Since this is a progress report, it is not possible to go into details of the action of our Committee during these three meetings. The Committee will be continued and the study will be enlarged until we can come up with a solution which will be agreeable to both the Profession and the State of Connecticut.

Respectfully submitted,
Joseph H. Howard

Physicians Attending Course in Nasal Reconstructive Surgery

(Continued from page 456)

Crispell, Lawrence S., Hitchcock Clinic, Hanover, New Hampshire
Curran, Timothy L., Hartford
Davis, James E., Hartford
Donnelly, W. Allen, Hartford
*Fischer, George G., Wilmette, Illinois
Friend, Amos E., Manchester
*Gunderson, Harvey C., Toledo, Ohio
Hadley, Richard B., Rye, New York
Haggart, Harry H., Cincinnati, Ohio
*Hinderer, Kenneth H., Pittsburgh, Pennsylvania
Jennes, Milton L., Waterbury
*Kirchner, John A., New Haven
Latimer, Marvin L., New Haven
Lock, Walter E. E., Johns Hopkins Hospital, Baltimore
*MacCready, Paul B., New Haven
Mancoll, Morris M., Hartford
McNally, William J., Montreal, Quebec
Merriman, Henry, Waterbury
Morrissett, Leslie E., Greenwich
Neidlinger, William J., Hartford
*Petrillo, Charles, New Haven
*Rittenhouse, Emoyr A., McKeesport, Pennsylvania
Samponaro, Nicholas, Torrington
Schechtman, Charles T., New Britain
Silverberg, Samuel J., New Haven
Simonton, Kinsey M., Mayo Clinic, Rochester, Minnesota
Sirota, Harvey H., East Hartford
*Snelling, Pinckney W., Hartford
*Tabor, Gilbert S., Millerton, New York
Truex, Edward H., Jr., Hartford
Tucker, Charles A., Hartford
Van Leuvan, James S., Meriden
Wenger, Alvin P., Johns Hopkins Hospital, Baltimore
Woodford, Chester N., Hartford
Zeman, Michael S., Hartford

*Cottle Course Alumni

LETTERS TO THE EDITOR

Case of D. L. vs. F. D. Ellis, M.D.

On the morning of February 8, 1951 I was called by the physician in charge at the plant in West Hartford and told that an employee of theirs by the name of D. L. had had some sort of spell in the parking lot a short time earlier and was being sent by ambulance to the hospital where I was to attend him. I went to the hospital where I examined him and found that he had had a cerebral accident which had involved his speech and the right side of his body. His right arm and right leg were not completely paralyzed because he could move them somewhat. He was conscious but could not talk coherently; and his mind seemed cloudy. This happened at a time when the hospital was filled to capacity and only cases of an emergency nature were being admitted. The question in his case was whether he could be classed as an emergency. If he had been unconscious, he could have been called an emergency and he would have been admitted. As it was, I decided that he was not an emergency and that he should be taken to his home. This was done. His improvement at home was rapid and after three days he was sitting up and out of bed and on the fifth day he was dressed and walking about. I treated him at his home at regular intervals until March 2 when he began to come to my office twice weekly for treatments. He continued to improve and was under my care until April 13, when he was discharged at his own request. He had been driving his car for about two weeks and had been back at work for over a week.

Then the question of payment for my services arose. Up to April 13 he had paid me only $10 on a total bill of $80. He ignored all communications that I sent him and refused to make any payments whatsoever. Finally I put the account in the small claims court for consideration. It was scheduled to be heard on July 13. In the meanwhile he filed a cross-complaint against me to the amount of $100, claiming that because he was denied admission to the hospital he lost the use of his hospital insurance amounting to $70, plus one week's wages of $30. The case was heard as scheduled and a judgment in my favor was rendered.

This case has several interesting angles from a medicolegal standpoint. Fortunately for me the case turned out favorably and my handling of his case turned out to be correct. But suppose he had not improved at home and an unfavorable outcome resulted, would not the defendant had grounds for complaining that I did wrong in not regarding his case as an emergency and having him admitted to the hospital? Furthermore, can a hospital legally refuse to admit a patient when he has been sent there by an outside doctor who had regarded the patient as a case for admission to the hospital? Furthermore, can a hospital refuse admission to a patient who has hospitalization insurance and who goes there seeking admission but is refused on the grounds of not being of an emergency nature?

I would like to hear from those doctors who are legally minded and who have had experience in such cases previously. It would be of interest to have legal opinions on those questions that I have raised above.

Respectfully yours,
F. D. Ellis, M.D.,
45 Cedar Street,
New Britain, Connecticut

Hartford Medical Society Features Beaumont Exhibit

June 1952 is the 130th anniversary of the meeting between Dr. William Beaumont and Alexis St. Martin at Detroit. The Hartford Medical Society will celebrate this event by an exhibit of some interesting material which will be on display at the Medical Library during the month of June.

This exhibit will include two letters from Beaumont to his parents, one dated St. Albans, 1811, and the second from Camp Seranac, Plattsburg, dated 1813. The original volume, "Experiments and Observations on the Gastric Juice and the Physiology of Digestion," by Beaumont published in Plattsburg in 1833, will be on display along with other biographical material.

Beaumont was elected an Honorary Member of the Connecticut State Medical Society in 1833. At the Annual Meeting of the Society in New Haven in May 1834, Beaumont presented his patient, Alexis St. Martin and described his experiments.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
First Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville



Mrs. Barnett Freedman

Message of President

As president of the Woman's Auxiliary to the Connecticut State Medical Society I am fully cognizant of the responsibilities and duties which I have assumed. I have done so, feeling that in these chaotic and uncertain times we each have a responsibility of citizenship. Not only as physicians' wives but as alert, aware citizens should each member of the Auxiliary make her contribution to the health and welfare of the community in which she lives.

Our program of Nurse Recruitment and Nurse Scholarship, Legislation, School Health and Public Relations are all vital and necessary. Only by being active members can we become familiar with the program as set forth by the National Auxiliary and interpreted by your State officers and chairmen.

This year I should like to see the base of our membership broadened. Eleven hundred members is a goodly number but not enough. Each member should make a conscientious effort to bring in a new member. The entire membership should become a more participating membership, each individual being as active in the Auxiliary as her time and ability will allow.

This is an election year. Every physician and every member of a physician's family of eligible age should register and vote. Our husbands are very busy men, serving the health of the public. It is we who must remind—must act—must be aware.

With your individual cooperation as members of the Woman's Auxiliary to the Connecticut State Medical Society, may this year be one of true progress, inspiration and accomplishment.

SLATE OF OFFICERS

At the eighth annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society on April 30, the following officers were elected for the coming year:

President, Mrs. Barnett Freedman, New Haven.

President-Elect, Mrs. Dewey Katz, Hartford.

First Vice-President, Mrs. Morton Arnold, Windham Center.

Second Vice-President, Mrs. Newell Giles, Darien.

Recording Secretary, Mrs. Edward F. Malloy, Stamford.

Corresponding Secretary, Mrs. Edward Wakeman, New Haven.

Treasurer, Mrs. Norman J. Barker, Collinsville.

The twenty-ninth annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Chicago June 8 to 13 at the Conrad Hilton Hotel. A cordial invitation is extended to all

members of the Woman's Auxiliary, their guests and guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general sessions of the Auxiliary.

REPORT OF WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

As President of the Woman's Auxiliary to The Connecticut State Medical Society, I have the honor to present the following report:

The eighth year of our organization, 1951-52, has been one with specific emphasis on "Working Together for Health," the theme chosen by our National President. Membership numbers 1,104, an increase of 41 members over last year. It has been our aim to strengthen and increase the membership, also to maintain an accurate file and mailing list of all members. Each of the seven organized counties has reported an increase in membership, although they have lost a few members for non payment of dues. Tolland county remains the one unorganized county but we have two members at large there. Three issues of the *State Auxiliary Bulletin* and notices of the annual meeting were sent to each potential member, also an invitation to become a member at large in the Woman's Auxiliary to The Connecticut State Medical Society if it seemed inadvisable to organize on a county basis.

The National Convention at Atlantic City, June 11-15, 1951 was attended by our quota of eleven delegates and the presidential delegate, also four alternate delegates. This was the first National Convention at which Connecticut had its quota of delegates in attendance.

The School of Instruction for all County Officers and Committee Chairmen was held September 10, 1951, at the New Haven Medical Association library. The morning was devoted to Civilian Defense with a talk and discussion by Dr. Harold S. Barrett, Health Service Division, Special Projects Branch, State Department of Health on the subject "Medical Aspects of the Civil Defense Program." Dr. Harry C. Knight, chairman of our Medical Advisory Committee, spoke to the group and clarified some questions of policy. The afternoon session was devoted to round table discussions conducted by the State Officers and Committee Chairmen.

The Semi-Annual Meeting was held November 1, 1951 in Hartford with the business session at Hunt Memorial at 4:30 in the afternoon. The members adjourned to the Hartford Club for dinner and heard Dr. Rufus B. Robbins, president-elect of the Academy of General Practice, speak on "Medicine in this Changing World." Husbands of Auxiliary members were guests at this meeting. The Annual Meeting will be held April 30, 1952 at the Hartford Golf Club, the speaker to be Dr. Perrin H. Long, professor of medicine, State University of New York College of Medicine, with "The Length of Life" as his subject. The National Auxiliary will be represented by Mrs. Harold F. Root, Brookline, Mass.

Invitations to attend the 1951 Annual Meetings of Maine, New Hampshire, Vermont, Rhode Island and Massachusetts were received. Mrs. Creighton Barker represented the Auxiliary at the first three, while the other two were attended by the President. The Auxiliary is honored to have the following State Presidents as guests for the Annual Meeting April 30, 1952:

New Hampshire: Mrs. Thomas Reid, South Berwick, Maine.

Rhode Island: Mrs. Joseph C. Johnston, Providence.

Vermont: Mrs. Clarence E. Fagan, Rutland.

Massachusetts: Mrs. William G. LeBrecht, Leominster.

The President, and President-Elect, Mrs. Barnett Freedman, attended the Conference for State Presidents and Presidents-Elect in Chicago, November 14 and 15, which was conducted by the National Officers and Committee Chairmen. All states and territories were represented except three, which proves somewhat the importance of this Conference. Today State presidents and presidents-elect consider attendance at the Conference one of the duties they assume when they take office.

Delegates to the Connecticut Health League have been Mrs. Morton Arnold, Public Relations chairman, the President and President-Elect. They have attended all meetings. Mrs. Creighton Barker attended the Public Relations meeting in Los Angeles in December and reported on it at the January Board of Directors' meeting. Mrs. Charles W. Goff, past president of the Auxiliary, was appointed a member of the Governor's Committee on Children and Youth, while Mrs. Ralph L. Gilman, another past president, is a member again this year of the National Public Relations Committee. The Auxiliary President served on the Program Committee for the New England Health Institute which is to be held June 18-20 at the University of Connecticut. She was chairman of the Sub-Committee, "Community Health Studies and Planning." Credit for the day's program goes to her excellent committee. She also represented the Auxiliary at two meetings in Hartford on Civil Defense called by Mrs. Ralph C. Lasbury for presidents of women's organizations in the state. At the National Convention in Atlantic City she was appointed a teller and in November elected secretary of the Conference for Presidents and Presidents-Elect in Chicago.

It has been her pleasure to attend meetings in all counties either once or twice this year. These meetings have been the highlights of her year; they have given her insight into the Auxiliary work at the grass roots level, also an opportunity for personal contact with the membership.

The Board of Directors, which includes the State Officers, Committee Chairmen and County Presidents, held six meetings; also there were two Executive Committee meetings. The president gives credit to her Board for the following results this year:

(1) *Art.* The 1952 exhibit of the Connecticut Physicians' Art Association will be held during the Annual Meeting in Rooms 141 and 142 at the Bulkeley High School. Members of the Woman's Auxiliary will again participate in the exhibit, also children of Society members are invited to submit entries.

(2) *Civilian Defense.* Six counties had speakers on the subject for their membership. Individual self preservation in time of attack or disaster has been stressed by taking Red Cross courses in first aid and home nursing, preparing the home with an emergency food shelf and equipment for disaster use. A number of our members are taking or teaching

these courses, while others are working in Red Cross Blood Banks as volunteer nurses or staff aides. Twenty members attended the Civil Defense Meeting at Hamden High School on February 26.

(3) *Editorial.* Four issues of the *Bulletin* of the Woman's Auxiliary to The Connecticut State Medical Society were published this year and sent to each member. Before the next issue a change in the name is planned.

(4) *Historian.* Files have been moved to the State Medical Society Building and records will be in order soon. We realize the importance of keeping our records up to date and of summarizing each year's work so that the continuous story of the progress and success of the Auxiliary is preserved for future reference.

(5) *Legislation.* County Chairmen have received the Lawrence letters and discussed them at their respective meetings. Information concerning the views of most of the presidential candidates is being distributed at the Annual Meeting.

(6) *Medical and Surgical Relief.* All counties took part in this program, collecting and sending to the New York City headquarters approximately 150 cartons of supplies.

(7) *National Bulletin.* Last year there were 384 subscriptions which rated second in the country. This Bulletin is published to keep local societies informed on national projects and policies. It is well worth the price of $1.

(8) *Nurse Recruitment.* Counties are cooperating with local hospitals and assisting during nurse recruitment week. Approximately 300 bulletins were mailed to high schools to inform interested students of dates and hours for Open House at Schools of Nursing throughout the State. This year five Auxiliaries gave scholarships to six medical students and six student nurses.

(9) *Publicity.* The Connecticut State Medical Journal has carried reports and news items from the State and counties. Publicity for the semi-annual and annual State meetings has appeared in the newspapers throughout the State.

(10) *Public Relations.* A pamphlet entitled "Your Community, Your Future" which emphasizes the importance of the role the doctor's wife plays in the Public Relations program, was formulated by this committee and sent to each doctor's wife in the State.

A picture story, "The Doctor's Wife," will appear in the May 24 issue of *Colliers.* Mrs. Daniel P. Samson, Thomaston, is the Auxiliary member featured in the story. The New Haven *Register* will carry an article on the story at the same time.

New Haven, Middlesex and Windham counties were successful in collecting and wrapping gifts at Christmas for the State mental hospitals. Hartford County collected specimens for Diabetes Detection Week, visited children at Newington Home for Crippled Children and patients in the tuberculosis ward at McCook Hospital, where gifts were given to 15 patients at Christmas. Twenty-five dollars was given to Norwich State Hospital toward the purchase of a television set and $100 to the Diabetic Summer Camp. Fairfield County gave Laurel Heights Sanatorium a small piano on rollers, 5 tables for record players, 87 L.P. records, books, bingo prizes and surprise packages at Christmas.

(11) *Revisions.* Revisions to the Constitution and By-Laws have been drafted, approved by the Board of Directors and will be presented at the Annual Meeting.

(12) *Special Gifts.* To date photographs of 76 Past Presidents of the State Medical Society have been collected. From now on it will be increasingly difficult to secure the 39 older photographs to complete the collection.

(13) *School Health.* This committee undertook the study of school health blanks in the State. The basis for the study was the survey entitled "An Integrated School Health Program" for New Canaan done last year by Fairfield County, which resulted in the adoption of Health Blank NOPHN63 for use in the New Canaan schools. The School Health Committee contacted school superintendents throughout the State and asked for copies of their school health forms. The response was excellent. This survey showed that the majority of the schools were using School Health Form No. 10 as recommended by the State Board of Education, which is similar to NOPHN63. This committee recommends that a school health form be worked out by the State Medical Society and the State Boards of Health and Education.

(14) *Today's Health.* It has been the aim of this committee to have every physician in Connecticut a subscriber to *Today's Health* with a copy available in his waiting room, and to acquaint the public with the magazine. Three thousand sample copies were distributed this year. The State Medical Society's Rural Health Committee was assisted at four county fairs. Gift subscriptions were obtained from the State Medical Society for our United States Senators and Representatives, also from Connecticut Medical Service for their employees. Final results show a 26 per cent increase over last year, a total of 386 subscription points. The sale of *Today's Health* needs more active support from the doctors before it can be more widely sold to any group.

The following recommendation was approved at the April 7, 1952 Board of Directors Meeting and will be presented at the Annual Meeting for approval:

That the Woman's Auxiliary to The Connecticut State Medical Society contribute $100 to the American Medical Education Foundation.

It has been gratifying to note the recognition the Woman's Auxiliary is now beginning to receive.

We are most appreciative of the financial contributions this year for our State *Bulletin* from the Connecticut Medical Service and the Connecticut State Medical Society.

To the Medical Advisory Committee, the executive secretary, the public relations director and the editor of the State Medical Journal for their advice and assistance throughout the year, the Auxiliary extends its sincere thanks.

Respectfully submitted,

Sally M. Tracy
(Mrs. F. Erwin)
President

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	*1443*	*968*	*1380*	*17*	*8*	*38*	*1142*	*132*	*131*	*12*	*26*	*54*	*552*	*52*	*179*	*634*
PERCENTAGES		*67.8*	*95.6*	*1.2*	*0.6*	*2.6*	*81.3*	*9.4*	*9.3*			*3.7*	*70.5*	*6.6*	*22.9*	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

SPECIAL NOTICES

EIGHTEENTH NEW ENGLAND HEALTH INSTITUTE

Institute sessions at University of Connecticut, Storrs

Preliminary Program*

June 18, 19, 20, 1952

"New Efforts for Health Improvement"

Wednesday Morning, June 18

Medical Facilities and the Older Worker — Room 1

9:30 Maintaining Health for Employment
Clark Tibbitts

10:30 A Working Program of Employment Arrangements for Older and Medically Handicapped Workers
Speaker to be announced

11:30 Industrial Insurance Recommendations and Experience with Older and Handicapped Workers
R. B. O'Connor, M.D.
General Discussion

Water Supplies Including Fluoridation — Room 2

9:30 Tastes and Odors in Water Supplies
F. W. Gilcreas
Discussant, Ellis A. Tarlton

10:30 Significance of Radioactivity to Water Works Superintendents
Rolf Eliassen

11:30 Fluoridation of Public Water Supplies — Panel Discussion†

The Dentist	Frank E. Law, D.D.S.
The Sanitary Engineer	Charles R. Cox
The Biochemist	Harold C. Hodge

Health Education — Room 3

9:30 How Social Science Can Help Health Education
Frederick L. W. Richardson, Jr.

10:30 and 11:30
Health Education — A Look Into the Future — Round Table Discussion
Moderator, Sol Lifson

Health Officer	Douglas H. Fryer, M.D.
Psychiatrist	Jules V. Coleman, M.D.
Nurse	Eleanor M. King
Adult Educator	Siegmar F. Blamberg, Jr.
Medical Service to Organized Groups	Irving S. Shapiro
Evaluation of Mass Media	Andie L. Knutson
Voluntary Agency	Nelson Kraemer
Health Educator	Mary Parks Armstrong
Summarizer	Ira V. Hiscock

12:30 Cafeteria luncheon and annual business meeting of New England Health Education Association. No advance reservation required

Mental Hygiene and Civil Defense — Room 4

9:30 to 12:20
Problems of Panic, Morale and Anxiety in Times of Stress — Symposium
Theodore P. Sohler, M.D.
Edward J. Humphreys, M.D.
Isidore Schnap, M.D.
General Discussion

Wednesday Afternoon, June 18

The Handicapped Worker — Room 1

2:00 Specific Advances in the Medical Management of Chronic Diseases
Malford W. Thewlis, M.D.

3:00 Alcoholism and Employment
Robert Strauss
Arthritis and Employment
Henry H. Kessler, M.D.

4:00 Health Education Through Compulsory State Disability Compensation Programs
John E. Farrell
General Discussion

Tuberculosis — Room 2

2:00 The Tuberculosis Problem in Connecticut
Paul S. Phelps, M.D.
Mass Radiography
Alan L. Hart, M.D.
Community and Industrial Organization and Education in Mass Radiography
William B. Parsons
Consultation Services
Reginald Edson, M.D.
Case Register
Roslyn MacNish

3:00 Recent Medical and Surgical Developments in Sanatorium Treatment
Nicholas A. Marinaro, M.D.
The Role of the Public Health Nurse in Tuberculosis Control
Helen M. Green
Laboratory Examinations for Tubercle Bacilli
F. Lee Mickle

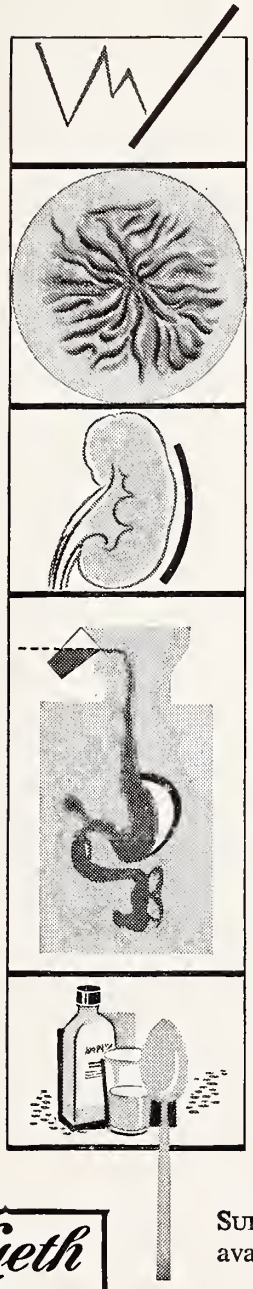
4:00 Student Nurse, Nursing Staff and Patient Education
Louise L. Cady
Educational Program of the Connecticut Tuberculosis Association
Mrs. M. Gilbert Burford
Discussant, William H. Morriss, M.D.

*Official programs to be distributed at the Institute will include a complete listing of session chairmen, speakers, their affiliations and so so.

†There is to be an afternoon conference of Connecticut water works officials which will include a discussion period; all interested persons are invited.

FOR THE PEPTIC ULCER PATIENT

"DOUBLE-GEL ACTION" **AMPHOJEL**



relieves pain promptly	stops gastric corrosion
promotes rapid healing	provides a soothing protective coating over the ulcer
no kidney damage	imposes no added burden on kidney function
never causes alkalosis	buffers gastric contents moderately; permits normal neutralization of alkaline secretions of upper intestine
no acid rebound	even in excessive doses. Does not cause unphysiologic alkalinity and consequent acid secretory response
pleasant to take	smooth, creamy, pleasing taste and texture

Wyeth®

SUPPLIED: Liquid, bottles of 12 fl. oz. Also available: Tablets of 5 grains and 10 grains

After 15 years of clinical use, still a leading prescription product for peptic ulcer—

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

AMPHOJEL®

ALUMINUM HYDROXIDE GEL • ALUMINA GEL WYETH

Wyeth Incorporated, Philadelphia 2, Pa.

HOME ACCIDENT CONTROL: THE COMMUNITY APPROACH — Room 3

2:00 Home Accident Prevention and the Official Health Agency
I. Jay Brightman, M.D.

3:00 Home Safety and the Voluntary Agency
Marjorie B. May

Home Safety and Other Official Agencies
Frederick S. Kent

4:00 Panel Discussion and Question and Answer

THE MENTAL HYGIENE CLINIC IN THE COMMUNITY HEALTH PROGRAM — Room 4

2:00 to 4:50

The Relations of Community Clinics to the Community
Abraham Z. Barhash, M.D.

When to Refer to a Community Clinic
Ella A. Dye

Overcoming Resistance of Patients to Clinic Referral
George E. Gardner, M.D.

General Discussion

Thursday Morning, June 19

REHABILITATION OF MEDICALLY HANDICAPPED WORKERS FOR GAINFUL OCCUPATION — Room 1

9:30 Re-Training and Emotional Rehabilitation
H. Houston Merritt, M.D.

10:30 Medical Services and Other Benefits for the Disabled Worker
Willis M. Weeden, M.D.

11:30 Varieties of Sheltered Work
Edward Hochauser

General Discussion

ENVIRONMENTAL HYGIENE — Room 2

9:30 Public Health Engineering Aspects of Realty Subdivisions
Charles H. Lawrence
Discussant, Eric A. Grub

10:30 to 12:20

Mechanical Dish Washing — Symposium

Manufacturers	A. H. Messler
Soap and Chemical Industries	T. D. Laughlin
Electric and Gas Utilities	John R. Beccia
Operators	Albert C. Bollen
Official Health Agency	Harold E. Thompson, Jr.

CHILD HEALTH — Room 3

9:30 Health of the World's Children
Martha M. Eliot, M.D.

10:30 Newer Knowledge in Child Development
Harold C. Stuart, M.D.

11:30 Emotional Aspects of Children with Physical Handicaps Who Have to be Away from Home
Anna L. Philbrook, M.D.

NUTRITION — Room 4

9:30 Nutrition for Older People
Malford W. Thewlis, M.D.

10:30 Nutrition and the Obesity Problem
Robert J. Anderson, M.D.

11:30 Recent Trends in Nutrition and Future Possibilities
George R. Cowgill

12:30 Cafeteria luncheon meetings of the Connecticut Public Health Association and the Connecticut Nutrition Council. No advance reservations required

Thursday Afternoon, June 19

ROLE OF THE LOCAL HEALTH DEPARTMENT AND OTHERS IN THE COMMUNITY CONTROL OF CHRONIC DISEASES — Room 1

2:00 and 3:00

The Practicing Physician
Benjamin V. White, M.D.

The Voluntary Agencies
Thomas D. Dublin, M.D.

The Health Officer
Alfred L. Burgdorf, M.D.

4:00 Panel Discussion

General Discussion

AIR HYGIENE AND INDUSTRIAL HYGIENE — Room 2

2:00 Air Pollution
Wesley C. L. Hemion

3:00 Role of the Nurse in Industry
Eleanor C. Bailey

4:00 Dermatitis in the Industrial Medical Program
Louis Schwartz, M.D.

MATERNAL HEALTH — Room 3

2:00 Maternity Care in Rural Areas

General Practitioner	W. Bradford Walker, M.D.
Public Health Nurse	Madeleine Y. Phaneuf
Hospital Administrator	R. Julia DeMayo

3:00 Maternity Care in Urban Areas

Obstetrician	Robert H. Wyatt, M.D.
Pediatrician	Howard Boyd, M.D.
Public Health Nurse	Edna S. Miller
Hospital Administrator	William J. Donnelly

4:00 Looking Forward to Better Maternal Health on Basis of Recent Progress Reports
Carl E. Johnson, M.D.

VENEREAL DISEASE CONTROL — VOLUNTARY HEALTH INSURANCE — Room 4

2:00 Value and Methods of Contact Interviewing in Venereal Disease Control
Robert R. Swank

Why Programs of Veneral Disease Control Must Not Be Relaxed
John W. Lentz, M.D.

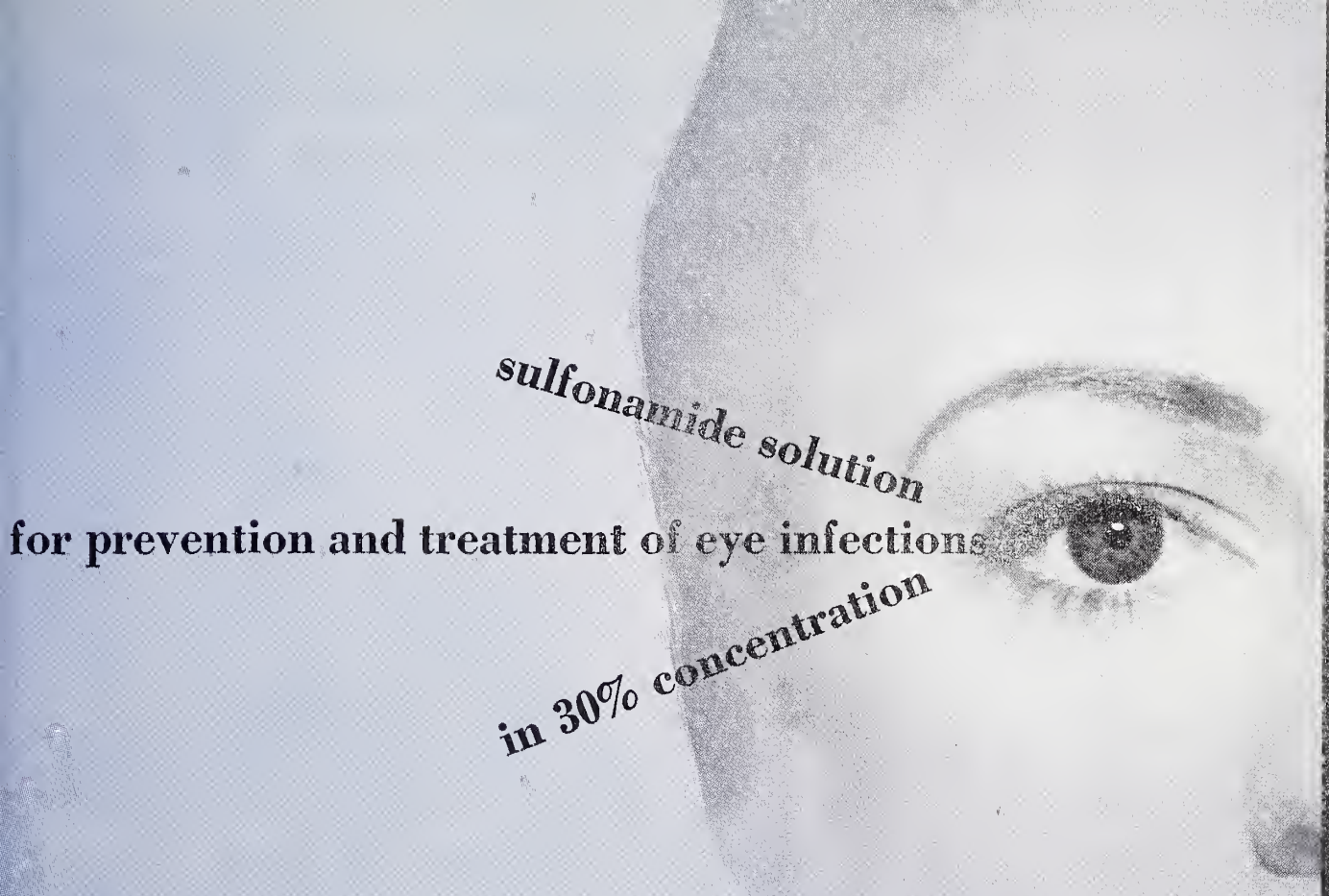
3:00 and 4:00

Voluntary Health Insurance Aspects of Medical Care—Panel Discussion
Moderator, William H. Horton, M.D.

Physicians' Medical Care Plans
James E. Bryan

Medical Care Plans of Commercial Companies
George E. Light

An Experiment in the Insurance of Preventive Medical Care
George Baehr, M.D.



sulfonamide solution

for prevention and treatment of eye infections

in 30% concentration

Higher concentration—Sodium SULAMYD® Ophthalmic Solution provides sulfacetamide, a sulfonamide soluble to a concentration of 30% *at physiologic pH*.

Wide therapeutic range—Effective against all common eye pathogens, both gram-positive and gram-negative.

Rapid, deep penetration—Higher solubility and concentration produce local therapeutic levels within 15 minutes.

Excellent results—In eye injury—no loss of working time in 98.87 per cent of one series of 11,953 cases; in eye infections—rapid healing.

Well tolerated—Outstanding freedom from irritation and sensitization.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Sodium SULAMYD Ophthalmic Solution 30%

(Sodium Sulfacetamide—Schering)

Sodium SULAMYD Ophthalmic Solution 30%: 15 cc. eye-dropper bottles.

Sodium SULAMYD Ophthalmic Ointment 10%: ⅛ oz. tubes.

Schering CORPORATION • BLOOMFIELD, NEW JERSEY

Sodium SULAMYD Ophthalmic Solution 30%

SCHERING

Thursday Evening, June 19

6:00 Institute Banquet (by reservation)

Friday Morning, June 20

DISEASE CONTROL — Room 1

9:30 The Relationship of Injections to the Occurrence of Paralytic Poliomyelitis
Robert F. Korns, M.D.

Recent Advances in Our Knowledge of the Virus of Poliomyelitis
Dorothy M. Horstmann, M.D.

10:30 Experience of New York State in Control of Rabies
Alexander Zeissig, D.V.M.

Important Animal Diseases Transmitted to Man and Their Control
James H. Steele, D.V.M.

11:30 Educational Programs in Diabetes Detection and Control
Hugh L. C. Wilkerson, M.D.

Prophylaxis of Rheumatic Fever
Daniel F. Levy, M.D.

TOWN MEETING FOR HEALTH — Room 2

Moderator, Carter W. Atkins

9:30 Citizens' Responsibility Toward Public Health
Reginald M. Atwater, M.D.

10:30 What Do We Have To Do?

Health Officer	Alfred L. Burgdorf, M.D.
Physician	Stuart L. Joslin, M.D.
First Selectman	Albert W. Clark
Board Member	Mrs. Richard L. White
Welfare Officer	Howard E. Houston
Chairman of Board of Education	Eleanor H. Little

11:30 How Can We Do It?
Thomas A. Hendricks

HEARING LOSS — CHILD DAY CARE CENTERS — Room 3

9:30 Recognition and Treatment of Hearing Loss in Children
William J. Neidlinger, M.D.

10:30 Rehabilitation of Children Who Are Hard of Hearing
Norton Canfield, M.D.

11:30 Child Day Care Centers and Nursery Schools — Symposium
Cornelia Goldsmith
Harriet C. Nash
Agnes L. Brown, M.D.

BETTER USE OF PUBLIC HEALTH NURSING POWER IN OUR COMMUNITIES — Panel Discussion — Room 4

Moderator, Eleanor M. King

9:30 to 12:20

Problems Involved in Combining Official and Non-Official Public Health Nursing Agencies and Ways in Which These Problems Have Been Resolved
Jane D. Keeler

Coordination Between a County Health Department and Private Public Health Nursing Agencies
Bosse B. Randall

Coordination of Local Public Health Nursing Agencies With a Full Time Health Unit
Lucy Gordon White

Coordination of Public Health Nursing Services in a Community from the Viewpoint of a Health Officer
Sidney Cobb, M.D.

How Amalgamation Has Been Achieved in Greenwich
Sybil P. Bellos

General Discussion.

Friday Afternoon, June 20

VIRUS DISEASES — Room 1

2:00 Virus Laboratories for Departments of Health
Werner Henle, M.D.

3:00 Serological Epidemiology: Its Application to the Study of Poliomyelitis
Joseph L. Melnick

4:00 The Enteric Viruses
Gilbert Dalldorf, M.D.

PLANNING FOR THE CARE OF THE PATIENT — Room 2

2:00 Planning Hospital Facilities for the Community
John J. Bourke, M.D.

3:00 A Community Plans for Out-Patient Care
Abbie E. Dunks

4:00 Care of the Patient After He Leaves the Hospital
Edith I. Epler
Joseph W. Reath
John F. Nolan, M.D.

DENTAL AND SCHOOL HEALTH PROGRAMS — Room 3

2:00 Orthodontic Problems in Pre-School Children
Wilbur D. Johnston, D.D.S., M.D.

3:00 Present Dental Health Needs of Children
Irving W. Eichenbaum, D.D.S.

4:00 Use and Abuse of Newer Knowledge of Growth and Development of School Age Children
Alfred Yankauer, M.D.

THE OFFICE WHEELS OF HEALTH AGENCIES — Room 4

2:00 The Position of the Non-Professional Worker on the Public Health Team
Clifford C. Shoro

3:00 Training Workers to Meet the Public
Barbara Lincoln

4:00 Using the Phone to Build Good Public Relations
Alden Cutler, Jr.

FIRST WORLD CONFERENCE ON MEDICAL EDUCATION

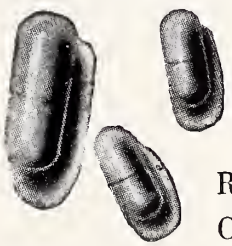
The World Medical Association announces that it will hold a World Conference on Medical Education in London, England, August 24-29, 1953. It is expected that the Conference will discuss the requirements for entrance to medical studies and the selection of medical students, social medicine, and the aims and content of the medical curriculum.

This Conference will precede the meeting of the World Medical Association in Amsterdam, Holland, in September 1953.

Terramycin



CAPSULES



Rapidly absorbed following oral administration, Crystalline Terramycin Hydrochloride Capsules elicit prompt therapeutic response in acute and chronic infections involving a wide range of organs, systems and tissues. Its broad spectrum of antimicrobial activity encompasses organisms of the bacterial and rickettsial as well as certain spirochetal, viral and protozoan groups.

Supplied: 250 mg., bottles of 16 and 100;
100 mg., bottles of 25 and 100;
50 mg., bottles of 25 and 100.

Terramycin is also available as:

Elixir, Oral Drops, Intravenous,
Ophthalmic Ointment, Ophthalmic Solution.

ANTIBIOTIC DIVISION Pfizer CHAS. PFIZER & CO., INC., *Brooklyn 6, New York*

OUR NEIGHBORS

Vermont

At the Clinical Meeting of the Vermont State Medical Society held at University of Vermont College of Medicine on May 15, William G. Young, formerly a member of the Hartford County Medical Association, discussed a paper on "The Problem of Psychiatric Referral."

The Annual Meeting of the New Hampshire and Vermont State Medical Societies will be held at the Mt. Washington Hotel, Bretton Woods, New Hampshire, September 7, 8 and 9.

NEWS
from County Associations

Fairfield

Frank C. McMahon was recently appointed Medical Examiner for the city of Stamford by the Fairfield county coroner, Edgar W. Krentzman.

William Kaufman of Bridgeport gave a talk in May before the Allergy Group of the New York Medical College entitled: "Some Allergic Aspects of Arthritis."

The regular monthly meeting of the Bridgeport Medical Association was held at Bridgeport Hospital on May 6 and was addressed by Dr. William A. Barnes, associate professor of clinical surgery at Cornell University Medical College and associate attending surgeon at New York Hospital who chose as his topic, "Surgery in the Diabetic." At the annual meeting of the Medical Examiners Association of Connecticut held in conjunction with the state meeting on the first of May, William H. McMahon, medical examiner of Norwalk, was chosen president of that organization succeeding William Weissenborn of Hartford.

Berkley M. Parmelee of Bridgeport recently returned from an extended cruise to South America.

Justillien H. Foret of Greenwich has resigned as a member of the staff of the Blythewood Sanitarium, to take up tropical medicine in St. John, Virgin Islands.

The Education Committee of the Bridgeport Chamber of Commerce in cooperation with the Bridgeport Board of Education sponsored "career days" at the three Bridgeport high schools, to provide third and fourth year students with first hand information on the training, education and interests needed in varied occupations. Speaking on careers in medicine were representatives of the Bridgeport Medical Association in Milton Lieberthal, John Paget and Thomas Tarasovic. Each spoke at their respective alma mater on the morning of May 6.

J. Stanley Nickum of Bridgeport passed away on April 8 and Thomas J. Roche died on April 30. Both were respected members of their profession and regarded highly by their fellow practitioners. Dr. Nickum was formerly chief of medicine at Bridgeport Hospital and Dr. Roche was chief of obstetrics for several years at the same institution.

Hartford

Sometime in June Hartford County Medical Association will hold a press-radio dinner conference. Members of the five dailies and nine radio stations in the county will be invited to discuss the mutual responsibilities that each group owes to the public in the matter of medical and health information.

* * * *

At their first meeting of the 1952-53 season, HCMA's Board of Directors elected Charles E. Jacobson, Jr., of Manchester as Board chairman. Dr. Jacobson who has his office in Hartford, is a graduate of Trinity College. He obtained his medical degree at Cornell and later on an M.S. in Urology from the University of Minnesota. He was at the Mayo Clinic for four years and has served on the Board of Directors since 1950.

* * * *

In a talk before the directors of HCMA Alfred Burgdorf, Hartford City Health Director, asked the county, which is part of the Hartford "target area" along with smaller parts of Tolland, Middlesex and Litchfield counties, to select representatives to work with these other counties in setting up a plan to assign doctors in the target area to emergency hospitals in cases of military attack by aggressor nations. Three physicians from the county will work with Dr. Burgdorf and the other counties in setting up this predisaster plan.

WHEN FOOD INTAKE *is inadequate*

When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

The appealing flavor of Ovaltine makes it acceptable to children as well as adults, including the aged. Ovaltine in milk is easily digested, an important feature when digestive disturbances are a factor.

Patients have the choice of either Plain or Chocolate Flavored Ovaltine, both of which are similar in their wealth of nutrients.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

During the month of March, tabulations from the Hartford night emergency call service showed a record 130 calls in which 45 doctors participated for the county. In only 57 calls did patients report that their regular physician was unavailable. And one M.D. handled 26 night calls during the month!

* * * *

In his report to the House of Delegates last April D. Olan Meeker, chairman of the Committee on National Legislation urged that the counties make some effort to discuss the Reed-Keogh bill, which would permit professional men to deduct from present income money toward a retirement fund, and that a vote be taken on its acceptance or rejection by the various counties.

Last April when this bill came to the attention of HCMA a letter signed by Thomas M. Feeney, secretary-treasurer, was mailed to each member of the county informing him of the stipulations in the bill and urging that he write to his congressmen on this matter. In the May issue of the County News Letter an editorial amplified the facts contained in the Reed-Keogh bill and again urged writing to congressmen for support of its passage. Responses from a senator and representative have already been turned over to the county for its files—and in both cases each agreed to give his attention to the bill when and if it came up for passage.

* * * *

Setting an example for the rest of the community, 65 New Britain doctors (three of whom are dentists) on the staff of the New Britain General Hospital have contributed $105,000 to a $600,000 fund for a new hospital wing. Plans for the new wing call for a total expenditure of $1,500,000 of which $900,000 has already been raised by a previous drive in 1941 and from the Hill-Burton Act.

* * * *

Four Hartford physicians, Norman M. Mann, Edward J. Conway, Benjamin H. Gottesfeld, and Leonard M. Lasser of the Blue Hills Clinic, writing in a May issue of the *Journal of the American Medical Association*, point out that Antabuse is an additional adjunct in the approach to the alcoholic, as it enables the patient to utilize more effectively psychotherapeutic procedures. In their article "Coordinated Approach to Antabuse Therapy," the doctors stressed the facts that the drug should not be used without accompanying pyschotherapeutic supervision and that great care should be exerted in the screening of candidates for the drug.

* * * *

Attending the American Society for Clinical Investigation meeting at Atlantic City last May were Drs. Wilson F. Smith, Chester Fairlee, Stewart Seigle and Edward Nichols.

* * * *

James M. McCormick, an assistant in the Department of Anesthesiology of the Hartford Hospital, left for Ireland for a month's stay at the beginning of May.

* * * *

Harry L. F. Locke, prominent pediatrician of Hartford, has been appointed by Governor Lodge as chairman of the health advisory committee to aid in the establishment and operation of a day camp for handicapped children and adults at the Harkness Estate in Waterford. Other physician members of the twelve man committee are Louis Spektor, chief of the Crippled Children Division, State Department of Health; Neil A. Dayton, superintendent of the Mansfield Training School; and Ward J. McFarland, orthopedic surgeon in New London.

* * * *

The Institute of Living announces the appointment to its medical staff of two former assistants in psychiatry at the Mayo Clinic, Ludwig M. Frank and Harold R. Martin.

* * * *

Thomas C. Hodgson, 82 years old, health officer and medical examiner for the town of Berlin from 1936 to 1944, died at the Hartford Hospital on April 21. Dr. Hodgson had practised in Berlin since 1906.

* * * *

The New England Obstetrical and Gynecological Society held its Spring Meeting in Hartford on April 23. Operative clinics were held at Hartford, St. Francis and Mt. Sinai Hospitals, followed by a dry clinic in the amphitheatre of the Hartford Hospital. Participating in the latter were Carl E. Johnson of New Haven, W. Leslie Smith, James E. Loftus and Hartwell G. Thompson of Hartford, and Katherine S. Quinn and E. A. Terry, Jr. of Bridgeport. Visiting speakers at the afternoon program held at the Avery Memorial Building were Richard W. Te Linde of Baltimore, John N. Connell of Jersey City, and James A. Corscaden of New York City.

From among all antibiotics, Orthopedic Surgeons often choose

AUREOMYCIN

Hydrochloride Crystalline

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

because

Aureomycin, following oral administration, diffuses rapidly into the skeletal and structural tissues of the body.

Aureomycin exhibits little tendency to favor the development of resistant bacterial strains.

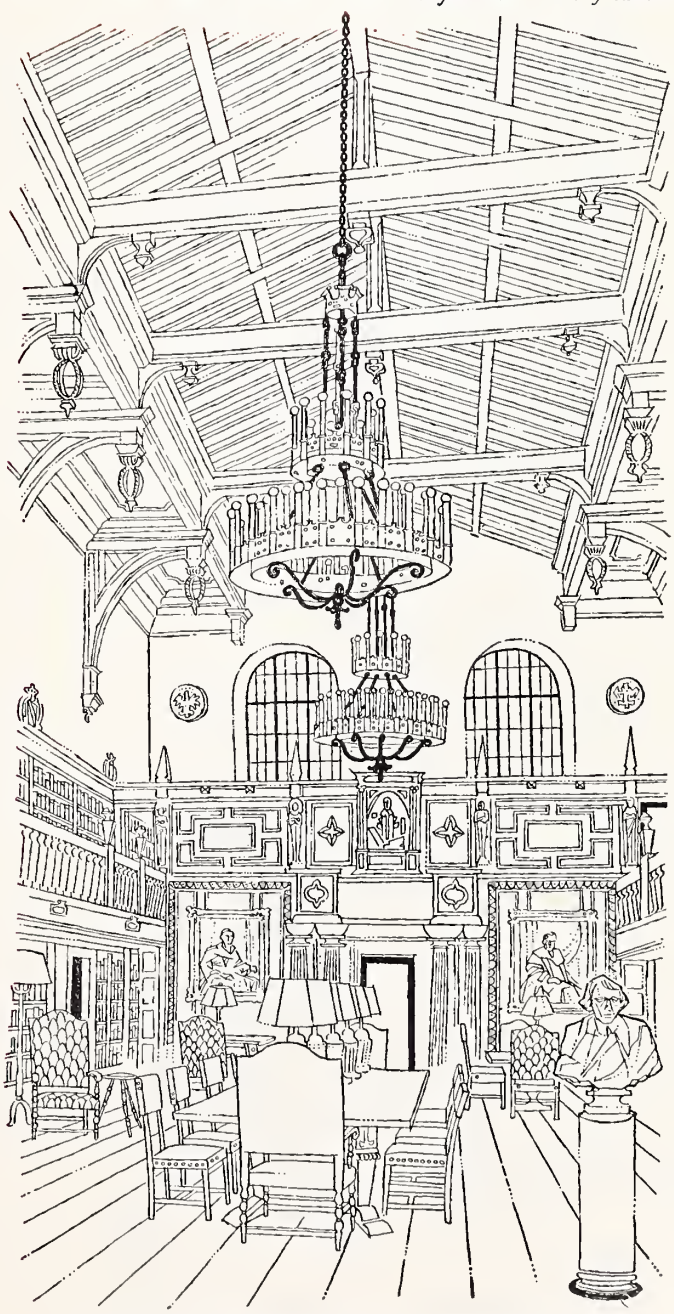
Aureomycin in daily repeated small dosage gives satisfactory serum levels, and may be continued over a long period.

Aureomycin has been reported to be clinically effective against susceptible organisms in the following conditions frequently seen by the orthopedic surgeon: Suppurative Arthritis • Osteomyelitis Infected Compound Fractures • Osteitis Brucella Arthritis • Periostitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 20, N. Y.



The Reading Room, Folger-Shakespeare Library, Washington, D. C.

Joseph H. Howard of Bridgeport, president of the Society, presided at the afternoon session and evening dinner and Louis F. Middlebrook of the local committee on arrangements presided at the dry clinic in the Hartford Hospital. Carl E. Johnson of New Haven and Stanley B. Weld of Hartford are members of the Council of the Society. The entire program was in charge of Louis F. James of Hartford.

Litchfield

George B. Bader, pediatrician of Washington, died suddenly on April 18 at St. Luke's Hospital, New York City.

Leo M. Davidoff of New Canaan, director of neurosurgery at Beth Israel Hospital, chief neurosurgeon at Mt. Sinai Hospital, and clinical professor of neurosurgery at the College of Medicine, (Post-Graduate) New York University, received the honorary degree of Doctor of Humane Letters at a special convocation in New York City on May 1.

Middlesex

Benjamin Roccapriore spent April 17, 18 and 19 in Boston taking a refresher course in obstetrics and pediatrics.

The annual meeting of the Middlesex County Medical Association was held at the Commodore MacDonough Inn on Thursday, April 10. Officers for the coming year were elected. The new president is William J. Tate; vice-president, Norman Gardner; secretary-treasurer, Christie McLeod. The speaker of the evening was Thomas P. Murdock of Meriden who spoke on "Current Trends in the AMA Program." At this meeting three new members were elected: Victor W. Higgins, who is in general practice in Essex; Horace J. Prescod, who is on the staff at the Connecticut State Hospital in Middletown; Sophie C. Trent, who lives in Middlefield and who is an industrial physician in Hartford.

New Haven

Georgio Lolli, research associate in the laboratory of applied physiology at Yale, is the author of "The Influence of Carbonated Water on Gastric Emptying" published in *The New England Journal of Medicine*, March 27, 1952. With Dr. Lolli are two research associates in the same laboratory as co-authors.

Francis L. Shay of New Haven died at the Hospital of St. Raphael on April 24 after a brief illness. Dr. Shay was 53 years old and had been engaged in general practice in New Haven since 1926.

Luca Celentano of New Haven has been appointed subarea medical director by State Civil Defense Director William Hesketh. Dr. Celentano will head the New Haven Civil Defense medical organization.

H. M. Marvin of New Haven addressed the 141st Annual Meeting of the Rhode Island Medical Society at Providence, on May 8. "Differential Diagnosis of Pain in the Anterior Chest" was his subject.

Clement F. Batelli, a member of the New Haven Department of Health for nearly 23 years, has been appointed permanent director of the Department. Dr. Batelli has been director of the Bureau of Tuberculosis and since the death of Dr. Linde, acting head of the Department of Health.

News from Yale University School of Medicine

Adolph Posner, associate surgeon at Manhattan Eye, Ear and Throat Hospital and associate attending ophthalmologist at Montefiore Hospital, New York City, was the guest lecturer at the Yale School of Medicine Post-Graduate Course in Ophthalmology on April 18. His subject was "Tonometry." Dr. Posner gave a historical review of the method and then gave a simplified practical discussion of the technique and the interpretation of the readings. The principal comments were given by I. Krasso deSuto-Nagy.

Francis P. Guida was the speaker on April 25 at the Yale University Medical School Post-Graduate Courses in Ophthalmology. His subject was "Lens Extraction With the Erisophake: Review of Method and Results."

There were many comments and questions from the floor.

NEW BOOKS IN REVIEW

RHEUMATIC DISEASES. Based on the Proceedings of the Seventh International Congress on Rheumatic Diseases. Prepared by the Committee on Publications of the American Rheumatism Association. *Philadelphia and London: W. B. Saunders Company.* 1952. 449 pp. with 126 figures and 63 tables. $12.

Reviewed by JOSEPH J. LANKIN

This volume is based on the Proceedings of the Seventh International Congress on Rheumatic Diseases held in New York City in June 1949. Although this convention was perhaps the finest of its kind, the book is almost three years behind. The highlight of the meeting was the group of reports on the effect of Cortisone and ACTH in rheumatic diseases. Since then, voluminous investigations have led to a more accurate and less optimistic appraisal. The advent of cortisone and other steroids has been a great stimulus to the interest and research in rheumatic diseases, with the result that new concepts have been developed, clarifying, replacing, or disproving some of those presented at the convention.

Many papers were presented by foreign authors. In order to extend inducement and courtesy to representatives from distant countries, the program committee was not very selective so that there is considerable "deadwood" mixed in with valuable information.

Most of the papers presented at the Congress have appeared since then in more complete form in various journals where they did not have to cope with the handicap of a time limit.

This volume, suffering greatly from the lapse of three years, will be of value to those specially interested in rheumatic diseases, more as a commemorative issue rather than as a reference book. I would not expect it to have much general appeal.

* * * *

A SEX GUIDE TO HAPPY MARRIAGE. By Edward F. Griffith, Member of Royal College of Surgeons. Licentiate of Royal College of Physicians. Introduction by *Robert L. Dickenson*, M.D. *New York: Emerson Books, Inc.* 1952. 352 pp. $3.

Reviewed by STANLEY B. WELD

The author of this book calls attention to the fact that since it was originally written 17 years ago it has experienced 25 editions and has had a wide sale in England, the British Commonwealth, and several European countries. This is the first American edition. The late Dr. Robert L. Dickenson has added his prestige to the book by writing a short introduction in which he points out the timeliness of such a volume in this country where college students are demanding more information to prepare them for married life.

This volume is very complete, discussing every conceivable phase of sex, marriage, conception, abortion, sterility, and marriage counseling which should interest the layman.

Prescription Perfect



RED LABEL • BLACK LABEL
Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.



Born 1820 . . . still going strong

JOHNNIE WALKER
BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

Not only does it afford information necessary to the prospective husband and wife, but many of the problems of married life are discussed which in the past through ignorance have produced disaster.

The addition of a chapter on "Marriage Counseling in the United States" by Robert W. Laidlaw, M.D. and Frances W. Dow is timely. The appendix contains an up-to-date catalogue of family-counseling services and one of planned-parenthood clinic services.

For the average engaged couple this book is almost too encyclopedic. It should serve as an excellent text for study in connection with college courses on happy marriage. One cannot wade through all the anatomical and psychological detail contained herein without realizing how much delusion there may be in married life. The author emphasizes the seamy side, the unhappy marriages, the shipwrecks to a discouraging degree.

The book is a bit stodgy and needs brightening up to become more attractive. Instead of using borrowed diagrams which suffer somewhat from their age, half tones in color as well as in black and white in larger numbers would add much to the appeal. The young couple looking for information must be given a volume that is attractive as well as authoritative. One may not agree with Dr. Dickenson that it is "neither feasible nor desirable to translate English into American." After all, the reading public in the two countries shows some evidence of dissimilarity.

THE YEARBOOK OF PSYCHOANALYSIS. Volume 7. Managing editor, *Sandor Lorand*, M.D. *New York: International Universities Press, Inc.* 1951. 271 pp. $7.50.

Reviewed by Francis J. Braceland

In the seven years of its existence, the Yearbook of Psychoanalysis has become a useful index of trends and advances in the field. Volume 7 continues the high standards of previous years, sifting from the voluminous literature of 1950 contributions of practical and theoretical importance. Included are good presentations of Freud's teaching and the early development of his thinking; a critical survey of post-Freudian dream contributions (part 2); and an excellent clinical paper on dream analysis. There follow papers on the application of psychoanalytic concepts to social science, on the development of the mental apparatus, on preconscious mental processes, psychodynamics, oral aggressiveness and ego development, and psychosomatic symptoms. Other themes of interest are the climacterium; the role of anxiety in depersonalization; termination of analysis; the role of emotions in the development of language and the acquisition of a second language; and psychoanalytic aspects of bureaucracy.

These selections, 21 in number, are brief, well written and informative. The Yearbook should be kept in mind as a useful source of reference.

The bibliography is extensive and the references up to date. The monograph is divided into thirteen sections, the first of which deals with basic physiologic considerations. The other twelve sections deal with the application of these physiologic principles to specific conditions, diseases, and types of patients. One section is devoted to the physiologic effects of ACTH and Cortisone on body fluid and electrolyte. This form of treatment, although it may have certain advantages in the eyes of this reviewer, lends itself to repetition and loss of interest. This allocation of separate groups of patients and diseases into sections may tend to stimulate the idea that there is an inherent difference about the approach to such patients rather than encouraging the concept that the solution to any problem is best achieved by the application of the same physiologic principles to the immediate case at hand.

This discussion, like many, when questions of therapy arise, seems to pay only lip service to the marvels of renal function, which have previously been discussed in detail, by recommending the use of a variety of elaborate solutions to compensate for losses from various sources. A great deal of emphasis is placed on refinements devoted to the quantitative measurement and replacement of fluid and electrolyte losses. Although this may be feasible in infants and small children, in sick adults who cannot be weighed, the accurate collection of the necessary data is always difficult and subject to many errors and variables. The energy and attention extended on such details tend to lead to the treatment of calculations rather than the care of the patient on the broadest and most direct terms. A good deal of selectivity is required on the part of the reader in differentiating important from relatively unimportant points.

This monograph contains an enormous amount of information. It is not recommended as a practical guide to the clinical use of fluid and electrolytes.

CALLANDER'S SURGICAL ANATOMY (New 3rd Edition.) *By Barry J. Anson*, M.A., PH.D., (MED.SC.), Professor of Anatomy, Northwestern University Medical School; and Malter G. Maddock, M.S., M.D., F.A.C.S., Elcock Professor of Surgery, Northwestern University Medical School. *Philadelphia and London: W. B. Saunders Company.* 1952. 1074 pp. with 929 illustrations. $14.

Reviewed by Irving Waltman

"Callander's Surgical Anatomy" has enjoyed a well deserved popularity since its first edition in 1933 and second edition in 1939. The task for the present revision fortunately fell into the hands of a very resourceful team composed of a competent surgeon and an anatomist of unusual capability. The result as might have been anticipated is a thorough and splendid modernization of this book.

The new "Surgical Anatomy" has maintained the original pattern of basic anatomic presentation followed by surgical approaches and considerations but there have been copious changes in the illustrations, and many new operative procedures have been included. The book has been reset in the very readable two column style and innumerable outstanding illustrations have been added. Some of these have been taken from Anson's fine "Atlas of Human Anatomy" but most have been obtained from the best portrayals available in the surgical and anatomical literature and they are unusually good. Considerable stress has been placed on anatomical variations based on many meticulous dissections. For example, the branching of the facial nerve, the blood supply of the esophagus, the origin and course of the cystic artery, the arrangement of the structures in the hepatic radical, the


COSMETIC DERMATITIS?
Clinical tests confirm the use of AR-EX Cosmetics for hyper-sensitive skins. Scented or Unscented. Send for Free Formulary.
AR-EX HYPO-ALLERGENIC COSMETICS,
Free Diagnostic Aid
Table of cosmetic irritants and allergens — an aid in diagnosing cosmetic sensitivity — sent to physicians on request.
AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.

distribution of the vagus nerve, and the blood supply of the colon are shown in complete detail so as to include every possible variation and anomaly.

There is considerable new material in the book on radical head and neck surgery, pulmonary and cardiac surgery, esophageal resections, radical gastric surgery with the combined abdominal thoracic approach, pancreatic resections, vagotomy, porta caval shunts, and many other topics which were not treated adequately or were not in the older editions.

The many revisions and additions have immensely improved this already popular surgical anatomy book, and it can be recommended highly as an outstanding surgical text of its kind, clearly and accurately written and beautifully illustrated.

THE CLINICAL USE OF FLUID AND ELECTROLYTE. By John H. Bland, M.D., Assistant Professor of Medicine, University of Vermont College of Medicine. *Philadelphia and London: W. B. Saunders Company.* 1952. 259 pp. with 75 figures. American Monograph Series. $6.50.

Reviewed by EDWARD NICHOLS

This discussion presents in great detail both fundamental knowledge and the more recent concepts related to the metabolism of fluid and electrolytes. The text is replete with Gamble type diagrams illustrating the distribution of water and electrolytes between the cellular and extracellular compartments of the body under a great variety of circumstances and conditions when the normal distribution is disturbed.

LIVING IN BALANCE. By Frank S. Caprio, M.D. *Washington, D. C.: The Arundel Press, Inc.* 1951. 246 pp. $3.75.

Reviewed by STANLEY B. WELD

This book, evidently written by a psychiatrist, belongs in that popular and ever increasing group written for lay consumption. It reminds one of the Steincrohn series but with this noticeable difference, that this volume deals with nervous, mental, psychological and sex problems rather than with organic, somatic disease.

The author has nothing new to offer and repeats himself several times throughout the volume, but the problems he discusses are very real ones in the economy of society today and bear repeated emphasis. Likewise his solutions are not new but, because they are so often overlooked and forgotten, need reemphasizing.

Each chapter contains one or more illustrations. The style is narrative throughout. Neuroses, marriage difficulties, sex problems, alcohol and suicide are discussed. At the close of the book ten poisons are listed capable of producing unhappiness and the methods of overcoming the same are given. A ten point plan is offered to aid in achieving "better health, increased happiness and greater success." The author's parting shot is: "Live scientifically rather than emotionally." Good philosophy and how much the world needs more of it! Unfortunately human nature with all its weaknesses will continue to present problems.

THE FIGHT AGAINST TUBERCULOSIS. An Autobiography by Francis Marion Pottenger, M.D. Introduction by *Roy G. Hoskins,* M.D., *New York: Henry Schuman, Inc.* 1952. 276 pp. $4.

Reviewed by NICHOLAS A. MARINARO

This is the story of a pioneer physician in the fight against tuberculosis. It is the thrilling narration of the author's role in the medical era between 1894 and 1952—from Koch to isonicotinic acid.

Dr. Pottenger modestly relates his origin, education, original contributions, and selection of the field of tuberculosis as his specialty. The latter was a very notable achievement because he was the first phthisiologist on the west coast.

He completely traces the evolution of our knowledge concerning pathology, diagnosis, and treatment of tuberculosis. Numerous references are made to his personal acquaintance with the giants in this field—Koch, von Behring, Brauer, von Leyden, von Pirquet, Gohn, Baldwin, Theobald Smith, Calmette, Trudeau, Biggs, Flick, and Osler.

It was a distinct pleasure to read this man's story because he contributed so much to the success of the antituberculosis movement. His style of writing is simple and direct, making for easy reading. It is a book of special interest to those in this field.

SEND THIS COUPON TODAY
for AVEENO . . . the new concentrate from oatmeal . . . for skin therapy.
Aveeno provides prolonged emollient action on irritated skin areas . . . controls pruritus ani and pruritus vulvae . . . relieves itching and skin irritation in general rashes, sulfa and penicillin rashes, eczemas and allergic reactions.
E. FOUGERA & CO., INC.
75 VARICK ST., NEW YORK 13, N. Y.
Please send professional samples of AVEENO®.
M.D.
ADDRESS
CITY STATE

CHANGES IN THE MEMBERSHIP AND FELLOWSHIP STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION 1949-1952

1918 to 1949 Prior to 1950, and since the year 1918, all physicians who were active members of their State Society were non dues paying members of the American Medical Association.

1949 Of the 144,211 members of the AMA in June, 1949, 77,723 were listed as fellows. Fellows paid dues to the AMA and received *The Journal A. M. A.*

1949 The House of Delegates of the AMA assessed all members of the AMA $25, but this assessment was voluntary and not compulsory. This was the only assessment made.

1950 There was no assessment in 1950. The AMA, for the first time, set the dues for membership in the AMA at $25 a year. If these dues were not paid by the end of the year the member was dropped for nonpayment; before he could be reinstated, it was necessary for him to pay the delinquent year's dues.

The 1950 dues did not include a subscription to *The Journal A. M. A.*

A member in 1950 again had to pay fellowship dues to receive *The Journal A. M. A.*, or could subscribe to it separately.

1951 The membership dues in the AMA in 1951 were $25 and included a subscription to *The Journal A. M. A.* Fellowship dues were reduced but no longer included a subscription to *The Journal A. M. A.*

1952 The same as 1951, except that there are no fellowship dues and fellowship cards are not being issued. Fellowship will probably be abolished after the Annual Meeting of the AMA in June, 1952.

The following summary will further clarify the changes from 1949 to 1952:

YEAR	MEMBERSHIP IN THE AMERICAN MEDICAL ASSOCIATION	FELLOWSHIP IN THE AMERICAN MEDICAL ASSOCIATION	SUBSCRIPTION PRICE OF THE JOURNAL A. M. A.
	Membership dues in the AMA never included Fellowship dues. Membership dues have been payable only through the County and State Societies.	Fellowship in the AMA was dependent upon membership in the State and County Societies and the AMA Fellowship dues were payable to the AMA and were in addition to the membership dues.	Since January 1, 1951, the price of *The Journal* has been included in membership dues; rates below for 1951 and 1952 are for nonmembers, and laymen. Anyone may subscribe to *The Journal.*
1949	Assessed $25 but payment not compulsory.	Dues of $12 included *The Journal A. M. A.*	$12
1950	Dues of $25 did not include *The Journal.*	Dues of $12 included *The Journal.*	12
1951	Dues of $25 included *The Journal.*	Dues of $5 did not include *The Journal.*	15
1952	Dues of $25 include *The Journal.*	No fellowship dues for 1952.	15

Table of Contents : July 1952

Remarks of Governor John Lodge at 160th Annual Meeting 491

Cancellous Bone Grafts in Fresh Fractures Coming to Open Reduction
Maurice M. Pike, M.D., and J. Whitfield Larrabee, M.D., Hartford 494

Bioelectric Correlates of Emotional States
L. J. Ravitz, M.D., Durham, North Carolina 499

Hereditary Hemorrhagic Telangiectasia With Pulmonary Arteriovenous Aneurysm
Samuel D. Kushlan, M.D., New Haven 505

Acute Disseminated Lupus Erythematosus in a Thirteen Year Old White Male
Nicholas H. Bentas, M.D., Jean A. Spencer, M.D., and Sidney L. Penner, M.D., Bridgeport 513

Rosacea With Complications: Case Report
Eugene F. Kalman, M.D., Bridgeport 517

Our Fading Heritage
Hartwell G. Thompson, M.D., Hartford 518

EDITORIALS

Hospital-Physician Relationship 523
The Limitations of Prognosis 524
The Problem in Mental Diseases 524
County P.R. 525
Where We Live 526
The Student American Medical Association 525
Bertner Foundation Award 1952 (Posthumous) to George Milton Smith 526

DEPARTMENTS

Progress in Clinical Medicine
A Note On the Management of Congestive Failure
Irwin S. Eskwith, M.D., Bridgeport 527
The President's Page 530
The Secretary's Office 531
The Historian's Note Book
A Note On Inoculation for Small-Pox in Colonial New England
Arthur S. Brackett, M.D., Bristol 540
News From Washington 550
Public Relations 555
Military Affairs 558
From Our Exchanges 560
Woman's Auxiliary 564
News From County Associations 568
News From Yale University School of Medicine 570
New Books in Review 572

MISCELLANEOUS

The Doctor's Office 529
Contributors to the American Medical Education Foundation 536
AMA—Chicago—June 9-13, 1952 544
Special Notices 566



Connecticut Medical Service

is proud to announce that
it has been awarded the

Seal of Acceptance

as a

VOLUNTARY PREPAYMENT MEDICAL CARE PLAN

by the

Council on Medical Service - American Medical Association

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI JULY, 1952 No. 7

REMARKS OF HIS EXCELLENCY, JOHN LODGE, GOVERNOR OF CONNECTICUT, AT THE 160TH ANNUAL MEETING OF CONNECTICUT STATE MEDICAL SOCIETY, HARTFORD, APRIL 30, 1952

Dr. Rafferty, Dr. Barker, officers and members of the Connecticut State Medical Society, distinguished guests:

It is a source of very great pleasure and satisfaction to me to be your guest speaker on this delightful occasion.

I say pleasure because of the opportunity which it affords me to break bread and meet with so many whom I am privileged to know as friends.

When I received your kind invitation, I noted with considerable awe the venerable age of your society. I began to reflect upon just what your sixteen decades of existence mean in terms of history. To evaluate properly the remarkable antiquity of the Connecticut Medical Society one might recall that when the Society was established in 1792, soldiers who were to fall in the Battle of Waterloo had not yet been born.

Washington Irving was a boy of nine. Neither Hawthorne nor his novels had been conceived. The thrones of Europe were occupied by figures which seem today mustily ancient to us. Catherine the Great was Empress of Russia. Louis XVI who reigned in France had still a year to go before losing his royal head. George III was King of England, and until only a short time previously had been the ruler of America. George Washington was only in the third year of his first term as President.

Accordingly, your roots were entwined with the roots of our very nationhood, a long and lustrous record in which every member of this Society is entitled to feel much pride and gratification.

Since becoming Governor I have had increasing opportunity to meet and work with members of the medical fraternity of our State. I have found an uncommonly large sense of public responsibility among your members. Over and again I have called upon doctors to assume important public posts, and on every occasion their services have been given willingly and enthusiastically.

Whether it be on the Governor's Committee on Children and Youth, or the Commission to investigate the need for expansion of medical training facilities in our State, or the committee to advise on the health uses of the Harkness Estate, or on the problems of mental health and numerous other public undertakings, the response has been prompt and gratifying.

These are all special services given in addition to the duties performed by so many of your members, year in and year out, on civic and state boards. Knowing what inordinate demands the profession can make on your time, I am all the more deeply impressed by the example of public spirit which you are setting to our fellow citizens.

I would hope that the great talent and capacity for accomplishment represented in your membership will be continuingly and increasingly applied in the important sphere of public affairs and public services. There are many reasons why the larger participation of the citizen would be a welcome asset to the public life of his community, his State and the nation. We who are entrusted with the affairs of government have much that we can profitably learn from the citizens whose background and training so often lie in the field of the professions and of hard-headed endeavor in practical enterprise.

Now I know that in some government circles it has been the fashion to minimize the commodity of common sense and to elevate the theorist to positions of high power and importance.

You and I can agree that theory has its place, an indispensable place in the conception of projects and in some of the phases of planning a project, but we

know, too, that theory can be an almighty headache when it is allowed to sway the decisions which go into the execution of a plan.

Just as we in government can profitably learn from our citizens who have had practical experience in the business and professional world, by the same token, it is highly essential that these same citizens be thoroughly aware of the problems faced by us who conduct the affairs of government. For it must be obvious that government, under our representative system, is a highly complex art. Most assuredly, people of your talents and experience recognize that the problems of government require for their proper solution not only the practical approach necessary in business relationships, but also methods and techniques which in the business field might be considered by the undiscerning tiresome, oblique and even needless.

You will agree, I am sure, that the worth of political and social proposals lies not only in their conformity to tested ideals, but also, may I suggest, in their timeliness and in the degree of their adaptability to existing circumstances. The reason why so many reformers fail is that, regardless of the worth of their programs, they neglect to take into account the highly important considerations of time and place. Grave harm to the very cause which they espouse may be done by those who try to solve political and social problems without first learning how these problems came to be and in what difficulties their roots may be entangled.

Therefore, the better that men of good will in government and men of good will in labor, business and the professions can come to understand one another's problems, the surer it is that these problems can be solved not only for the good of the groups concerned, but for the well being of the people as a whole.

We live in an era when government has been permitted and even encouraged to inject itself into the lives of the people to an extent unprecedented in our history. It is a time when as a nation we should do well to pause and reflect upon the great words of Lincoln on this theme.

"The legitimate object of government," said Lincoln, "is to do for a community of people whatever they need to have done, but cannot do at all, or cannot do so well for themselves in their separate and individual capacities. In all that the people can individually do as well for themselves, the government ought not to interfere."

Therein resides an essential truth which no amount of sly political theorizing, no amount of impassioned demagoguery should ever be allowed to obscure. And I am convinced, ladies and gentlemen, that despite the contrary trend of our times, Lincoln's concept is also the sound, quiet instinct of the vast majority of the American people. Our citizens have come, in growing numbers, to realize that as the people become more dependent on government, government becomes less and less dependent on the people and tends to assume an arrogant existence of its own.

In the field of public health, this issue of government help as against government interference has been, as you so well know, very sharply drawn in our nation. Early and repeatedly I have made my stand clear on that issue. To me the idea of socialized medicine is an abhorrent concept. I am very strongly opposed to socialized medicine. It is an alien and repulsive doctrine which would interpose a bureaucrat between the physician and patient and would deny the citizen his centuries-old right to select for himself, his wife and his family, the doctor of his own choosing. It would also lower the standards of the medical profession and it would encourage malingering.

On the other hand, the health of our citizens is a basic state and national asset, and the question of the long-term protection of health is so complex that government obviously must assist private agencies in the general effort toward its solution. Our community, State and federal health departments, our tuberculosis sanatoria, our mental hospitals, our government operated clinics are legitimate and necessary instruments of such public service. So, too, I feel is the commission which I established last December to study the question of enlarging Connecticut's present facilities for medical training. Two of your distinguished colleagues, Dr. Barker of New Haven and Dr. Hastings of Hartford, are members of this commission from which we have every reason to expect a helpful and soundly based report.

Your representatives in government carry a responsibility to provide intelligent and honest leadership at all times. Assuredly they should leave no doubt regarding their position on what I feel is the central domestic issue of our time—the question of how much room is to be left to the individual by the activities of government, room to be everlastingly cherished and safeguarded for the exercise of the freedom, the energy and the enterprise of the citizen.

Within this city, within our State, within the borders of our country, we face complex issues which must be resolved justly and effectively for the well being and progress of our people.

Our domestic problems are caused in great part by world conditions and by the conduct of our foreign affairs. There is an interdependence here which we cannot ignore. At this juncture when our national security is ominously threatened, when some 60 billions of our annual federal budget is earmarked for national defense and for military and economic aid abroad, and at a time when increasingly our energies must be directed toward producing the tools and weapons of defense, it is obvious that the solution of our urgent domestic problems is involved in our success in resolving the crowning issue of war and peace—the issue, yes, of life and death.

I do not need to stress to you that this is a touch-and-go time. The problems and the omens of the day are the gravest in the history of our nation. In Korea, in Indo-China, in Malaya and in other troubled places, two million men are at war. Perhaps ten times as many more are under arms while daily, throughout the world, are raised new levies of marching men.

For us in the United States this assuredly is not a time for business as usual, not a time for politics as usual. It is, instead, a time for profound and anxious search beneath the husk of truth into the heart of truth. It is a time for reflection. It is a time also for reflection upon our past, upon our own inspiring heritage.

You who represent the field of medicine, with its own inspiring heritage will understand that I do not mean that we should attempt to dwell in the past, oblivious to the dynamic stream of history. If we today inspect the past, it is only that we may find better means of helping to rescue the anxious present and to preserve the future. Thus inspired and challenged we can, in our own day, create traditions and institutions which shall win for our generation in its turn a grateful remembrance.

How marvelously the medical profession of our day exemplifies that concept! It is not so long ago that in preventing and curing infections doctors had only a handful of specifics on which to rely. How the questing mind of the medical scientist has multiplied these remedies in today's amazing roster of antibiotics, vitamins, hormones, blood derivatives, detoxicants and vaccines! The genius, the conviction and the sense of service that are being brought to the fight on disease make it certain that in our time medicine will wring from soil and water and vegetation new and more wonderful drugs for our healing.

The x-ray machine which the world has long taken for granted has been in the service of our health for only a little more than half a century. Today, this indispensable technique is being supplemented by the products of the plutonium plants, as physicians trace life processes, both in health and disease, through the use of stable and radioactive isotopes.

The physician and the public health agency are together enabling a larger and larger proportion of our citizens to enjoy better health through a longer span of their life range. In this one field alone the profession is entitled to our heartfelt gratitude. But while these remarkable advances should be a source of very deep satisfaction to every member of your great profession, I am sure you are all aware that the victories won are more than matched by the problems which persist.

The very increase in life-span which you have helped to bring about has, in its turn, seemingly induced new and ominous problems for you. We are all sobered by the rapid increase in the number of deaths from cancer, from ills of the heart and arteries and other degenerative diseases. Beyond the widening circle of medicine's triumphs lies the vast penumbra of the little known and the vaster darkness of the unknown, extending through infinite reaches to the ultimate problem of the nature of life itself.

Ladies and gentlemen of the medical profession, we honor you for your continuing achievements; we rejoice with you in the opportunities which pose an enduring challenge to the skill, the integrity and the everquesting spirit of a profession whose members exemplify many virtues, but none more tellingly than the greatest earthly virtue of all, compassionate interest in the well being of your fellowmen.

CANCELLOUS BONE GRAFTS IN FRESH FRACTURES COMING TO OPEN REDUCTION

Maurice M. Pike, M.D., and J. Whitfield Larrabee, M.D., *Hartford*

For many years we have been concerned about slow healing in most of those fractures of long bones which, because satisfactory position and alignment either could not be obtained, or having been obtained could not be maintained, must necessarily come to open reduction.

Therefore, in the past five years we have been following a clinical series of cases, in order to determine to our satisfaction whether or not at time of open operation coincident use of cancellous bone grafts about the fracture sites would cause an acceleration of time of healing, so that earlier return to economic usefulness could be attained. Most cases of fracture of long bones can be well handled by closed methods, but there are some cases in which continued efforts to obtain satisfactory position can only result in malunion, delayed union, or nonunion. We feel that by prompt open reduction of these fractures, with coincident use of cancellous grafts, time of bony consolidation can definitely be accelerated.

The problem of bone growth and bone repair is fascinating, and has occupied many experimentally minded surgeons ever since John Hunter in the middle of the eighteenth century successfully transplanted a spur of a cock to its head. Belchier's studies on madder fed hogs; Macewen's epoch making replacement of a humeral shaft with bits of bone taken from osteotomies; and finally Albee's permanent contributions in bone surgery have resulted in making the bone graft operation an accepted and rational procedure.

Recent advances in our knowledge of bone graft material have made it seem certain that cancellous bone is superior to cortical bone in production of satisfactory union. This is so because it is apparently more osteogenetic, and more easily revascularized than cortical bone. Bone graft material has gone through much and valuable experimentation. Availability of heterogenous bone seemed to make it desirable but it has not been satisfactory. We then modified heterogenous bone and *os purum* was tried and it failed us. *Os novum* gave us little if anything more. Therefore we come back again to the use of human bone as graft material. However, we are faced with the choice between the use of cortical human bone and cancellous human bone. It definitely seems to us that cancellous bone is more satisfactory for grafting purposes in most cases. Abbott, Saunders, and Bost in 1942 found cancellous bone to be highly osteogenetic. Dick in 1946 concluded that the more cancellous the bone is, the more its transplanted cells are accessible to blood and intracellular nourishing fluids which will tend to keep them alive.

The reservoir is available and convenient. The ilium can be used with minimum mutilation and maximum safety. Cancellous bone under functional strain in four to six months becomes cortical in character. Luckey and Adams have pointed out the advantages:

1. Availability; 2. Less interference with skeletal structural integrity; 3. Replacement and consolidation more rapid; 4. More of the bone cells live and the time occupying transition of "creeping substitution" does not need to be awaited.

Causes of failure of bone graft are well stated and in their proper order by Ellis, Langston and Ellis:

1. Sepsis; 2. Application of graft under strain; 3. Inadequate nutrition of graft; 4. Lack of proper adequate immobilization; 5. Lack of protection until union is solid.

Finally, to sum up, let us consider the conclusions of Abbott, Schottstaedt, Saunders and Bost in their animal experiments, and also borne out by their clinical application:

1. Mature elements of either cancellous or cortical bone seldom survive. Those that survive are the cells of the periosteal or endosteal layers;

2. Cortical bone is almost all mature and possesses strength, but little growing power;

3. Cancellous bone is loose in structure and pattern, with interlacing trabeculae, each of which is covered with endosteal cells of high osteogenetic power;

4. Cancellous bone because of this loose structure is more easily revascularized, and the process of "creeping substitution" of Phemister is more easily accomplished.

Therefore, more or less in summary of the above and from our own experience, we have come to the following conclusions:

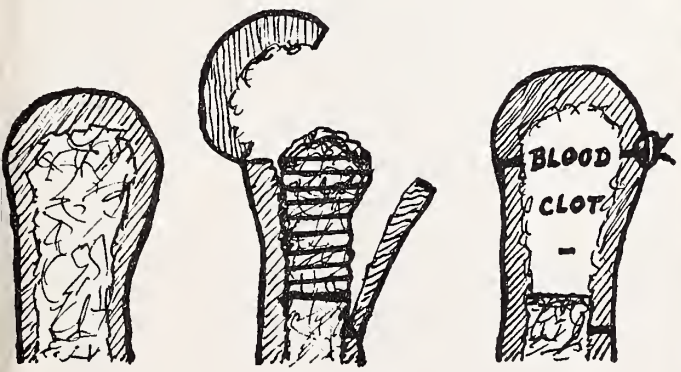
1. If we believe in Wolff's law at all, cancellous bone should rapidly take on the strength of cortical bone.

2. It is available without danger to the structural integrity of the skeleton.

3. It can be borrowed, as M. O. Henry of Minneapolis has pointed out, from relatives preferably, or from friends.

4. Through the development of the bone bank, now an adequate reservoir should easily be available.

A great many patients complain of the discomfort in the region of the ilium when iliac bone is used, as much or more than the injury to the leg. We would like to call attention to a very useful method of avoiding this discomfort. The method of taking iliac bone described by Robertson and Barron (Figure 1) in the *Journal of Bone and Joint Surgery* seemed to us at first a little foolish and too meticulous, but where we did not need a great deal of bone but simply the pure cancellous bone used in these cases, we have found this an excellent method. The patients have practically no pain postoperatively and they are left with a minimum of deformity as a result of the removal of the iliac bone.



A METHOD OF TAKING ILIAC BONE
(After Robertson and Barron)

FIGURE 1

It is with these thoughts in mind concerning cancellous bone that we decided because we had had difficulty with fractures of both bones of the forearm, and particularly fractures in the lower third of the tibia in which healing after open reduction is most decidedly delayed, to try and see if we could find out what cancellous bone would do for us.

The usual type of fracture of long bones presents no particular problem. With our methods of closed reduction and immobilization, as Sir Reginald Watson-Jones puts it, complete, continuous, and without interruption, good results are usually obtained. But there is another group where closed methods will not and cannot produce results that promise a good functioning limb and an early return to economic usefulness. It is this group that we wish to consider.

Following the fascinating results with cancellous bone replacement of bony defects that came out of the recent war, we wondered if some speeding up of time of bony consolidation could not be obtained by using cancellous bone as graft material, in those cases of fractures of long bones where closed reduction was unsatisfactory or impossible.

We now will present some representative cases of a group of patients in which, for the most part, closed reduction had completely failed, and in which, in each case, we used cancellous bone grafts at an open reduction, as early as compatible with the patient's condition. We will, however, present the details of only five of the eleven cases, as these are representative of the entire series:

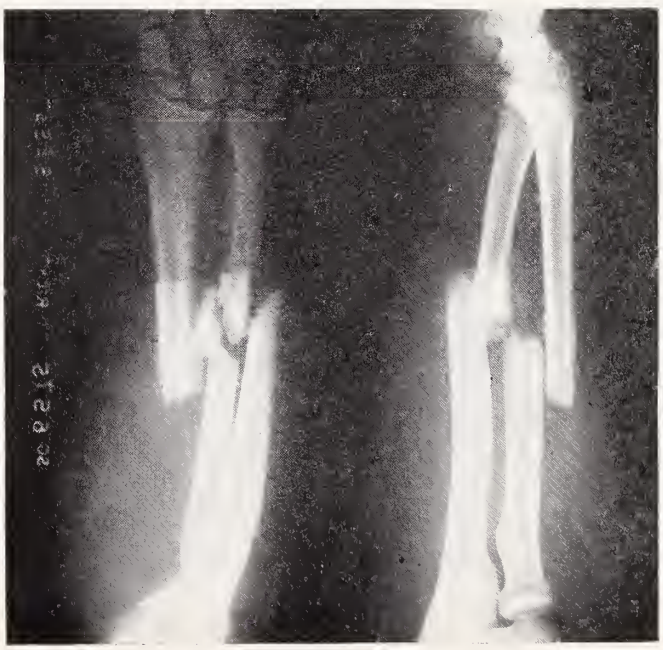


FIGURE 2A

CASE I

J. B., 21 year old male, injured 5/25/47. A fracture of the right radius and ulna, mid shaft; associated fracture of the waist of scaphoid bone (Figure 2A). Closed reduction not satisfactory. Open reduction 6/18/47. Radial fixation with 4 screw plate and ulnar fixation with iliac cortical bone graft. Both fracture sites treated with "barrel stave" and cancellous "crumb" grafts. Uneventful recovery. Good healing at 73 days. End result good (Figure 2B).

CASE II

M. A., 33 year old female. Injured 6/3/47. Fracture of both bones of the right lower leg, unsuccessfully treated at another hospital (Figure 3A). Open reduction 6/13/47 with a 6 screw plate and 2 transfixation screws and multiple cancellous "barrel stave" slips and cancellous "crumbs." Walked in 112 days with good union evident (Figure 3B). Ambulation was delayed by marked circulatory stasis. Good end result.

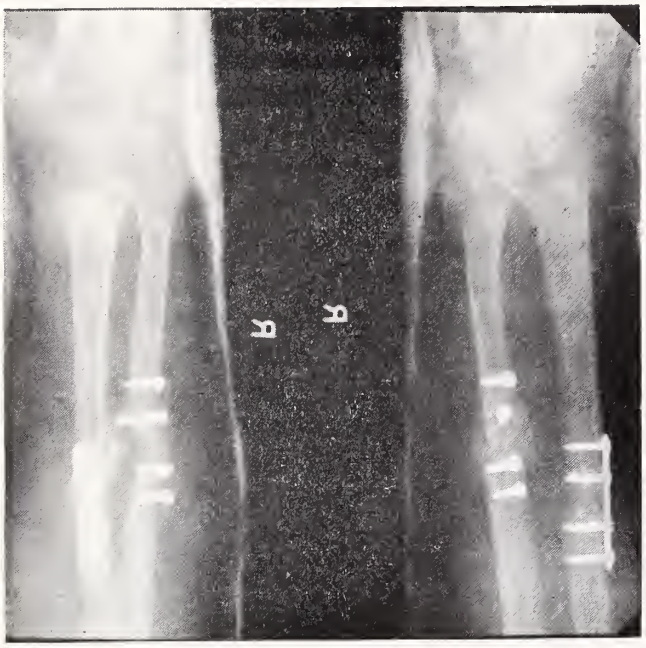


FIGURE 2B

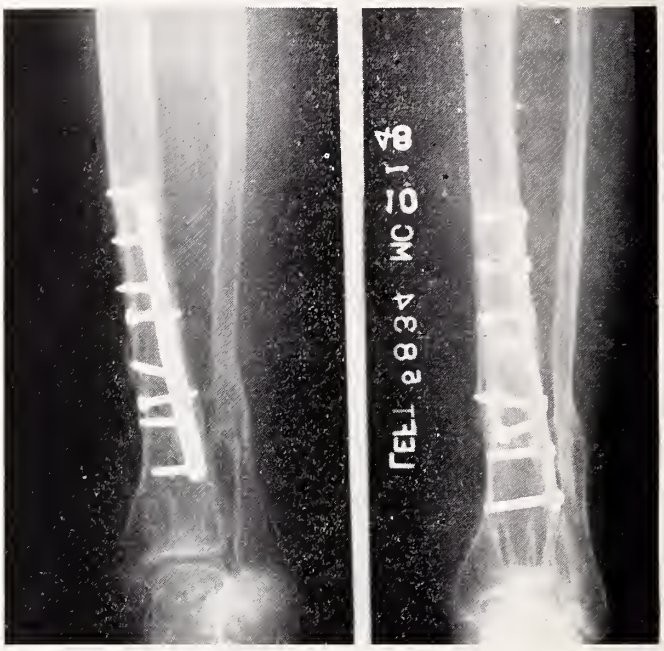


FIGURE 3B



FIGURE 3A

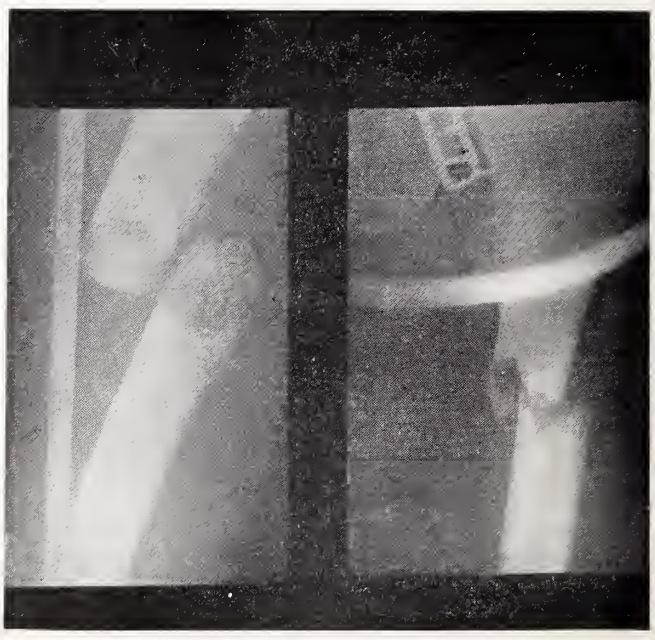


FIGURE 4A

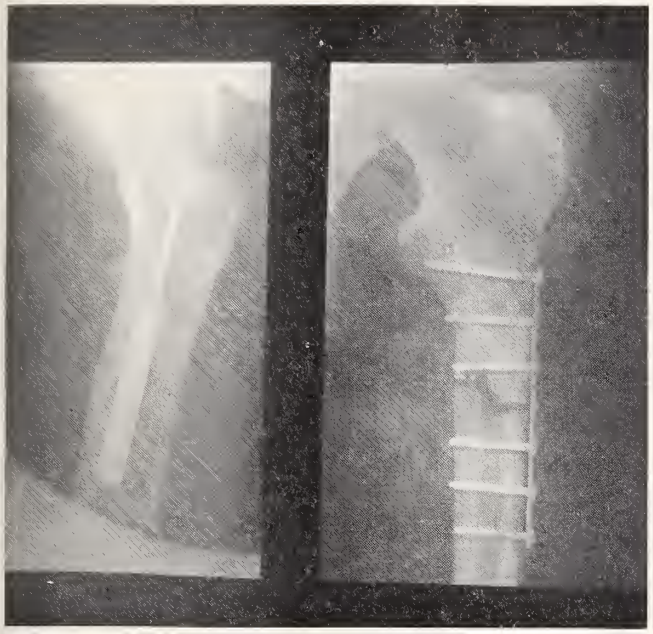


FIGURE 4B

CASE III

C. T., 48 year old male involved in an industrial accident. Sustained a severe comminuted fracture of the proximal end of the femur, 11/24/47 (Figure 4A). Closed reduction failed. Open reduction 11/27/47. Fixation by means of a 6 screw plate, "barrel stave" cancellous grafts and multiple cancellous "crumbs." Good callus evident six weeks post-operative. Full weight bearing 90 days (Figure 4B). Good result.



FIGURE 5A

CASE IV

J. N., 23 year old female. Injured in a skiing accident on 1/28/48. Oblique fracture of tibia and oblique comminuted fracture of mid fibula. Satisfactory closed reduction, which two weeks later was found to have slipped (Figure 5A). Open reduction with bone plating, "barrel stave" cancellous grafts and multiple cancellous "crumbs." Very rapid consolidation. Was able to walk well at 63 days. Good result (Figure 5B).

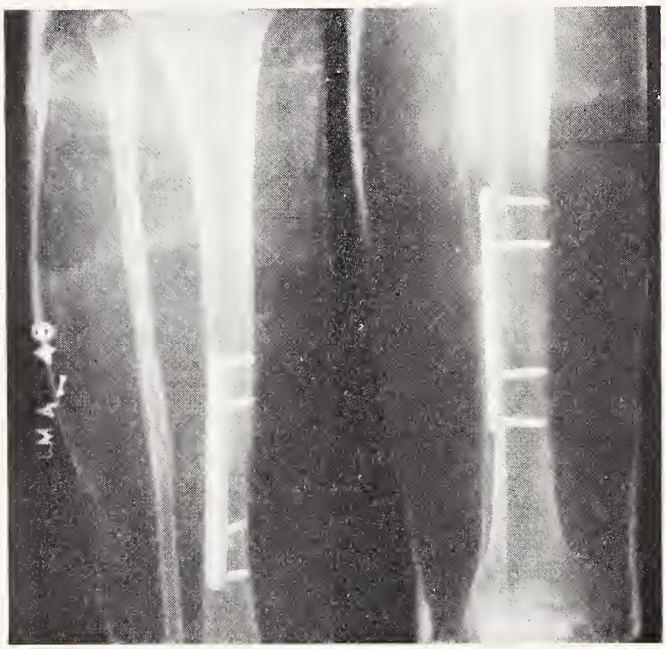


FIGURE 5B

CASE V

H. P., 50 year old male, on 3/22/48 was walking down a country road at 2:00 A. M. and was knocked down by hit and run driver. On admission he had a transverse comminuted fracture of the left tibia, and a fracture of the proximal end of the fibula. Closed reduction showed only fair results. Open reduction, 4/19/48, with a 4 screw plate and one transfixation screw, using "barrel stave" cancellous grafts and cancellous "crumbs." Considerable febrile reaction (104° on the 6th day). Fever promptly subsided with penicillin therapy. Because of persistent slight fever his cast was bivalved on the 15th postoperative day and wound was inspected. There was slight purulent discharge, and culture showed staphylococcus aureus, 4 plus. He was given adequate antibiotic therapy. X-rays three and one-half months postoperative showed apparent union of the cancellous graft material about the fracture, but no evidence of union in the cortical bone of the tibia. Absorptive changes were seen about all screws. On 8/6/48 the plates and screws were removed. On 2/17/49 debridement and iliac bone grafting was done. Good consolidation was present on 9/9/49, 553 days post-trauma against 71 days average in the other cases.

The results in these successful cases would indicate that prompt operation in these types of sliding fractures, supplemented by adequate fixation and use

of cancellous bone applied promptly after injury, causes a decided acceleration of healing time. We are all well aware of the time it takes to get union in fractures of both bones of the forearm, particularly if there is any malposition whatsoever. In our cases, where correct reduction was done, supplemented by adequate fixation and the use of cancellous grafts, clinical union was sufficiently firm at the end of 74 days (Table 1) to allow satisfactory use of the arm, and an excellent result was obtained. In the case of fractures of both bones of the leg, all of which were at the junction of the middle and lower third, clinical union, according to our criteria of no mobility under firm clinical manual force, and x-ray evidence of advanced healing, was present on the average in 71 days. In the case of the fractures of the femur, healing, according to our yard stick, was satisfactory in an average of 91 days.

Table 1

AVERAGE NUMBER OF DAYS TO FUNCTIONAL CONSOLIDATION

Radius and ulna	2 cases	74 days
Tibia and fibula	6 cases	75 days
Femur	3 cases	91 days
Average: accident to consolidation		77 days

For the purpose of comparison we went over 10 consecutive cases of open reduction of the tibia and fibula which were done prior to the present series. The figures on these are not exactly comparable, as we had not planned our follow-up on the same basis. However, in these 10 cases the average time to ambulatory consolidation was approximately 94 days as compared with 71 days in the present series; a saving of 23 days!

Comparing these cases with the results of Funsten and Lee which they published in 1949, we feel that there is definitely an acceleration of healing time. True, their criteria were somewhat different. Their criteria of clinical union were lack of mobility and a palpable mass of callus. Their x-ray criteria were much more advanced. They required an x-ray appearance of complete connective callus between the fracture ends. Under their clinical criteria they had an average of 19 weeks or 133 days, whereas, in our cases, using cancellous bone graft on those fresh fractures, we had an average period of time until ambulation of 71 days. In the cases of fracture of the femur our patients walked at 91 days. In the report of Funsten and Lee they did not state definitely their time of clinical union in their femoral cases, but we would estimate from their paper that union in the proximal end was approximately at 75 days. However, again we would not permit patients to walk merely on clinical evidence of lack of mobility, because union might not be solid. Their x-ray criteria showed complete union at 25 weeks or 175 days.

We feel that this series of cases is much too small to be very conclusive. There is, however, no gainsaying that it is highly suggestive (Table 2). This series definitely suggests that the method employed resulted in a distinct acceleration of healing time, and therefore is a definite advance in fracture therapy.

Table 2

CASE	DATE	FRACTURE	USEFUL UNION	END RESULT
I	2- 9-47	Upper femur	94 days	Good
II	5-25-47	Radius and Ulna	73 days	Good
III	5-30-47	Tibia and fibula	63 days	Good
IV	6- 3-47	Tibia and fibula	112 days	Good
V	10- 8-47	Radius and ulna	74 days	Good
VI	11-24-47	Upper femur	90 days	Good
VII	1-23-48	Tibia and fibula	99 days	Good
VIII	1-28-48	Tibia and fibula	63 days	Good
IX	3-22-48	Tibia and fibula	533 days	Poor
X	1- 1-49	Upper femur	88 days	Good
XI	4-10-49	Tibia	71 days	Good

In summary, therefore, we will say that in these types of fractures we feel prompt open reduction with internal fixation and cancellous bone grafting will promote more rapid recovery. Infection at all costs must be avoided. Meticulous surgical technique and constant, watchful after care is essential. The use of antibiotics, though helpful, will not cover up a serious error in technique. The results demonstrated here indicate that recovery in these fractures, when cancellous bone is used, is more satisfactory and healing is more prompt than one could possibly expect with the use of conservative closed methods, or with the use of open reduction and simple bone plating.

CONCLUSIONS

1. Union is demonstrably more rapid.

2. Restoration to an ambulatory status is much earlier.

3. Return to economic usefulness is much accelerated.

4. The one great cause of failure is infection.

REFERENCES

1. Macewen, W.: Growth of Bone, J. Maclehose and Sons, Glasgow, 1912.

2. Albee, F. H.: Bone Graft Surgery, Saunders, Philadelphia, 1915.

3. Abbott, L. C., Saunders, J. B. de C. M., and Bost, F. C.: Arthrodesis of Wrist with Use of Grafts of Cancellous Bone, J. Bone and Joint Surg., 24:883, 1942.

4. Luckey, C. A., and Adams, C. O.: The Use of Iliac Bone in Bone Grafting and Arthrodesis, J. Bone and Joint Surg., 28:531, 1946.

5. Ellis, V. H., Langston, H. H., and Ellis, J. S.: Failures in Cortical Bone Grafting, The Lancet, 2:561, 1947.

6. Abbott, L. C., Schottstaedt, E. R., Saunders, J. B. de C. M., and Bost, F. C.: Evaluation of Cortical and Cancellous Bone as Grafting Material, J. Bone and Joint Surg., 29:381, 1947.

7. Henry, M. O.: Homografts in Orthopaedic Surgery, J. Bone and Joint Surg., 30A:70, 1948.

8. Robertson, I. M., and Barron, J. N.: A Method of Treatment of Chronic Infective Osteitis, J. Bone and Joint Surg., 28:19, 1946.

9. Funsten, R. V., and Lee, R. W.: Healing Time in Fractures of Shafts of Tibia and Femur, J. Bone and Joint Surg., 27:394, 1945.

BIOELECTRIC CORRELATES OF EMOTIONAL STATES

L. J. Ravitz, M.D., *Durham, North Carolina*

Ever since Galvani's frog leg observations, it has been generally recognized that electrical phenomena can be correlated with many forms of biological activity: e.g., the electrical impulses accompanying muscle contraction, as in the electrocardiograph, or the voltage changes associated with cortical activity, as in the electroencephalograph. Some 20 years ago, Dr. Harold S. Burr of the Yale School of Medicine, instigated a planned program of investigation of the electrical properties of living systems. However, before work could be started, it was necessary to construct new measuring devices which would not disturb the living organisms being studied. Until the advent of the vacuum tube, most instruments drew the current necessary for their operations from the creature under observation. This produced unreliable measurements, and so with the assistance of Cecil Lane (professor of physics at Yale) and Leslie Nims (senior investigator at Brookhaven), Burr perfected a microvoltmeter by means of which voltage differences between any two points on or in a biological system can be measured with virtually no disturbance of it.[1] Reversible, "non-polarizing" Ag-AgCl electrodes immersed in physiological saline are connected to this instrument which employs, essentially, a Wheatstone bridge circuit with high input impedance, high sensitivity, and high stability, in order to measure DC potentials as pure voltage gradients independent of current and resistance changes.

To date, more than 100 studies have been carried out on all living systems. For instance, potential differences can be correlated with various stages of embryonic development.[2] By measuring an electrical pattern in frog eggs, it is possible to predict the longitudinal axis of the developing nervous system before fertilization has even occurred.[3] The standing potential in corn kernels indicates hybrid vigor of the resulting plant predicting growth rates, weight of ears, and height of stalk.[4] Ovulation time can be detected by this procedure[5] as can malignancy of the female genitourinary tract.[6] Despite repeated failure to observe electrometric changes from trance states, it is even possible by this technique to determine quantitatively depth of hypnosis (Figure 1) which has been compared to DC alterations under sodium amytal narcosis, drowsy states, and sleep.[7]

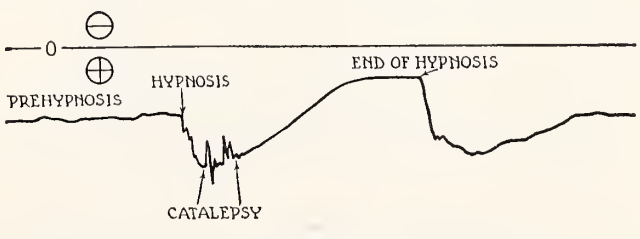


Figure 1

Schematic DC tracing of hypnosis

From the Section of Neuro-Anatomy, Yale University School of Medicine, New Haven, Connecticut, and the Department of Neuropsychiatry, Duke University School of Medicine, Durham, North Carolina

Presented at the 97th annual meeting of the North Carolina State Medical Society, Section on Neurology and Psychiatry, Pinehurst, North Carolina, May 9, 1951

Because of these striking results, it was felt worthwhile to take daily readings on a group of students and professional persons—at the same time keeping careful records of emotional disturbances and mood fluctuations, local variations in the external environment such as temperature, barometric pressure, humidity, weather and sunlight, and comparing all these variables with finger potentials, oral temperature, blood pressure, pulse, continuous DC records and EEGs.

DC electrode placement was established mainly on a trial and error basis. After experimenting with various electrode placements, it was felt that the most consistent results could be obtained by summating a bilateral series of 4 potential differences between head and anterior chest wall:

HOT (GRID) ELECTRODE		COLD (GROUND) ELECTRODE
right temporal region	—1—	right chest, midclavicular line
right temporal region	—2—	left chest
left temporal region	—3—	right chest
left temporal region	—4—	left chest

Such a combination tends to wash out any errors in single determinations. Two series were taken at each reading, following which the results in millivolts were averaged two ways:

1. Arithmetic summation of absolute voltage gradients without respect to signs.

2. Algebraic summation of voltage gradients with respect to signs, e.g.:

LEAD	1ST SERIES	2ND SERIES
1	−5	−5
2	−6	−8
3	+3	+2
4	+3	+3
1—summation of absolute voltage gradients	17	18
2—summation with respect to signs	−5	−8
$Mean_1$	17.5	
$Mean_2$	−6.5	

Polarity always refers to the head reading relative to the chest.

As DC determinations are beset with numerous pitfalls, considerable experience is necessary before reproducible results are achieved, particularly since the instruments are extremely sensitive and must be handled with understanding. Differences in electrode pressure may produce errors, particularly over bony prominences, although if care is taken, such alterations are not significant. Even blood flow and temperature variations produce modifications sufficiently small as to be lost in the results of other variables and can be safely ignored when working in the millivolt range.[8] Further, there is sufficient evidence to conclude that electrical phenomena measured by these instruments are tied in a basic and vital way to the biological activity of the entire organism or to the region bracketed by the electrodes, and are not passing accidents of perhaps pragmatic consequence.

Seventeen subjects, consisting of 11 men and 6 women, were measured daily from 1 to 8 months via spot determinations. Sixteen were university students or house-officers in their 20's or early 30's; the seventeenth was a 48 year old artist. Careful notation was made of daily mood fluctuations and experiences, and information concerning life histories was pieced together from casual conversations; this material was secured through daily contact, for a very congenial atmosphere was maintained. After several weeks' contact with the subjects, more subtle nuances of mood could be detected. Sufficient information was obtained to evaluate each individual including the essentials of his particular emotional problems, particularly since most subjects were, at one time or another, observed under stress. At first, subjects had readings twice a day, although this was reduced to one daily reading when it became evident that there was in general no significant difference between early morning and evening readings, or between readings before and after meals.

The first results were disappointing; minor mood swings could not be correlated with DC alterations. However, despite complex individual variations, there appeared in all subjects considerable potential increases every 14-17 days which astonishingly occurred approximately at the time of the full and new moons—usually preceding or following the lunar day by 24-72 hours. Sometimes there was a marked potential decrease at one of these times. This phenomenon varied somewhat among the subjects and in order to ascertain further whether it occurred at the same time for all, 5 day running averages of the combined daily means of 6 subjects measured for the longest period of time were plotted with and without signs (Figures 2 and 3, line 8). The cyclic pattern was not eliminated by individual potential variations and appears more obvious in graphs plotted with respect to polarity than without. Further studies of 63 subjects at Duke revealed the same cyclic phenomenon.

Since 1943, continuous DC records have been taken of elm, oak, or maple trees in New Haven or Old Lyme, Connecticut, with electrodes permanently embedded in the growing layer of the tree, the cambium. These trees have shown similar lunar cycles unrelated to changes in the immediate environment.[9] Likewise, there was no correlation between temperature, humidity, barometer, weather, and sunlight in humans. By connecting a microvoltmeter to electrodes immersed in a column of saline and taking continuous readings for several months, during which time there was no potential change, the possibility of recurring instrument artifact has been ruled out.

Finger potentials did not indicate these cycles, remaining relatively constant for a given individual except in women during ovulation, at which time, there was also an increase of head-chest potential differences.

All subjects were placed arbitrarily in 3 groups without regard to DC results: A—the severely maladjusted, B—the moderately maladjusted, and C—the reasonably well adjusted. A few typical examples follow:

B-14 volunteered for the experiment due to interest in his own marked mood swings. His head was almost uniformly negative to his chest. There was a

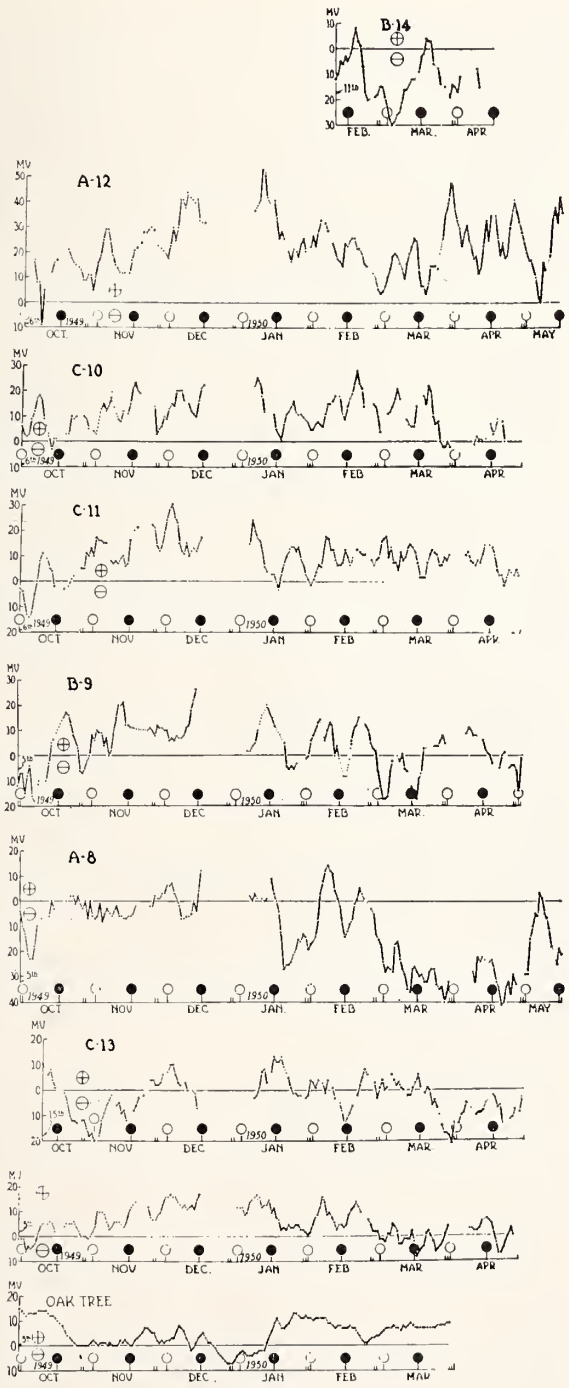


FIGURE 2

Algebraic 5-day running averages of mean daily PDs during different lunar phases

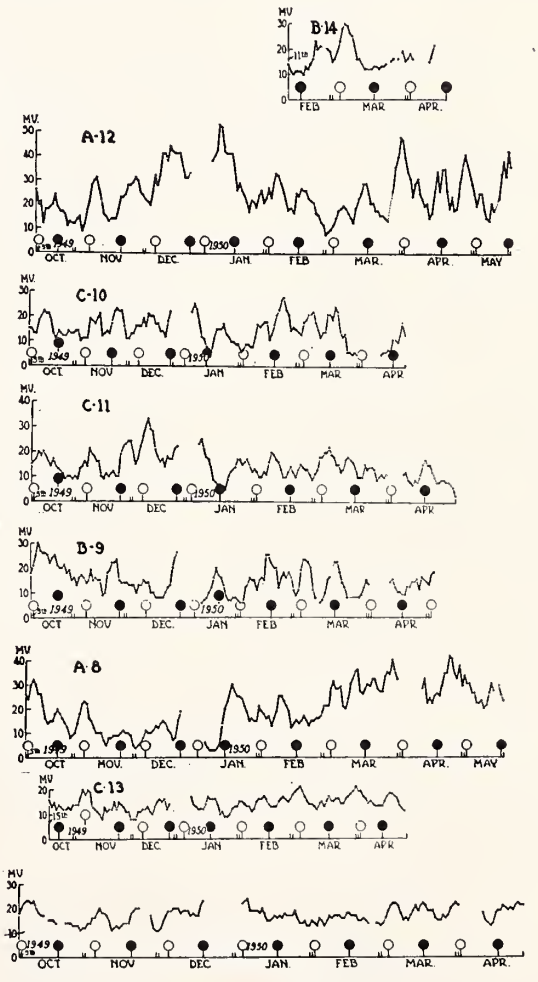


FIGURE 3

Arithmetic 5-day running averages of mean daily PDs during different lunar phases

uniform, predictable cyclic pattern for the two months readings were taken. Increased potential negativity exceeding −15 millivolts was usually to be associated with sullenness, general irritability, hypersensitivity, preoccupation, and to some extent withdrawal from people and all social activities. Emotional conflicts concerning passivity in interpersonal relationships was always present. Subject felt best when readings of increasing positivity were obtained. During February and March, such positive voltage shifts occurred shortly following the new moon; periods of greatest negativity approximated the full moon.

A-12 showed a regular cyclic rhythm which was almost entirely positive, although isolated negative potentials occurred. There was a definite correlation between mood and potential: apathy, pent-up hostility, aggressiveness, irritability, insecurity, and general withdrawal from people usually coincided with summated potentials exceeding +40 millivolts; conversely, enthusiasm, conviviality, general amiability, and the subjective feeling of well being were almost uniformly associated with low positive or negative readings. Increasing insecurity, withdrawal, autistic thinking, and suspiciousness coincided with gradually increasing potenials from October through the first part of January; this sustained mood was consciously felt by the subject as was his general improvement during February and March. At this time, which coincided with considerably lower potentials, A-12 said that he felt less sensitive to other people and enjoyed being with others much more. His daily work tended to go more smoothly, and he appeared more sociable and less introspective and isolated. Potentials taken before, during, and immediately following a vigorous rubdown remained unaltered. In general, his best moods were accompanied by readings below +12 millivolts—also rare readings when his head became negative to his chest.

Cyclic variations in C-10 were regular; DC spikes were generally predictable within 2 days. The subject tended to feel more energetic, tense, and generally keyed-up when his potentials were of greatest magnitude. At such times his working capacity seemed to increase.

The records of C-11 are remarkably similar to those of C-10. During December he tended to be unhappy and slightly irritable. From February until the experiment ended his mood improved, and he felt more relaxed and contented. This was associated with lower potentials and a tendency for 7-9 day cycles to appear.

B-9 showed a definite, though somewhat irregular, cyclic rhythm. He was usually tense, and although significant mood swings rarely could be detected, low positive or negative readings were usually associated with a generally less tense appearance. Because of a tendency toward hypertension, his physician prescribed a phenobarbital mixture which did not alter appreciably either blood pressure or standing potentials.

A-8 showed considerable fluctuation as regards polarity from October-December, although 14-17 day cycles are evident on his graph plotted as to absolute voltage gradient during this period. In January, A-8 was under considerable pressure studying for midyear examinations; his head tended to become increasingly negative to his chest. From the end of February until readings were stopped the subject was having serious conflict regarding his love life. It was difficult for him to concentrate and he tended to neglect his work. This occurred concomitantly with increased potential negativity. After satisfactory emotional outlets became available in March, he was better able to study despite continued conflict concerning his sexual escapades. High isolated positive or negative potentials were often associated with diffuse hyperactivity, tenseness, facetiousness, and emotional lability. As in the others, no discernible correlation was found to exist between temperature, blood pressure, pulse, and standing potential.

Changes in polarity occurred frequently in C-13 as is evidenced by the graphs; with signs, there appear to be 6 week cycles in addition to 2 week cycles—the latter being most evident when absolute voltage gradients were plotted. Voltage fluctuations were minimal as compared to other subjects, which may be attributed to the fact that the others were considerably younger, as it is known that younger trees and mice tend to show much wider voltage swings relative to older ones.

In all subjects there seemed to be a correlation between regular well defined 8-12/second (alpha) rhythm of the electroencephalogram, stability of continuous DC tracings, regular rhythmic cyclic variations, and personality stability. Those whose basic orientation was toward passivity and dependence showed a much greater quantity of alpha rhythm than did those who were basically active, independent, aggressive, and driving. Using these criteria, first formulated by Leon Saul and Hallowell Davis,[10] the amount of 8-12/second rhythm in the left occipital region (alpha index) was predicted in 9 out of 11 EEGs taken.

Although subjects were classified independently of DC results, the A group showed significantly higher positive and negative potentials than the B and C groups—the C group showing the lowest. The normal monthly mean was roughly −7 to +18 millivolts, or when plotted as absolute voltage gradients, 8 to 18 millivolts; any consistently sustained values exceeding this in either direction seem pathognomonic of psychic disturbance.

The potentials of the entire group were gradually rising through November and December—a period of emotional disturbance for A-12 whose potentials increased at an accelerated rate far above the others during this time. A-8 was in constant turmoil during March and April; his high negative readings occurred simultaneously with potential decreases in the others, and although unresolved conflicts continued, he felt and acted better when his potentials began to increase in positivity during May. At this time there is some indication that A-12 and C-13 were likewise beginning to show signs of increasing positivity. C-10 and C-11, whose potentials had been decreasing until April, tended to level off; had their readings been continued through May, it is possible that they too, would have begun to show increased positive potentials (Figure 4). This suggests that emotional disturbances may be aggravated, in part, by universally present exogenous or endogenous forces acting upon or within the individual. Although highly speculative, from the consistency of polarity in all subjects, it seems possible that those with generally positive potentials might tend to manifest greatest conflict and emotional disturbance when there is a trend toward increased positivity and be most adjusted when there is a trend toward decreased positivity, whereas the opposite might hold true for those with generally negative potentials. Infinitely more work must be done before this can be ruled out or accepted as valid hypothesis. At any rate, rhythmic variations found in 80 subjects to date suggest that no individual can be completely assessed without considering him in relation to his own cyclic pattern.

It will be seen at once that this data raises extraordinarily interesting problems; one concerns the possible role played by the sympathetic nervous system in this picture. Yet trees which have no nervous systems show similar cyclic variations. Actually, the potential difference is measured between a large cluster of cells at one point related to another collection somewhere else in the same system with electrodes of relatively giant size compared to the cells

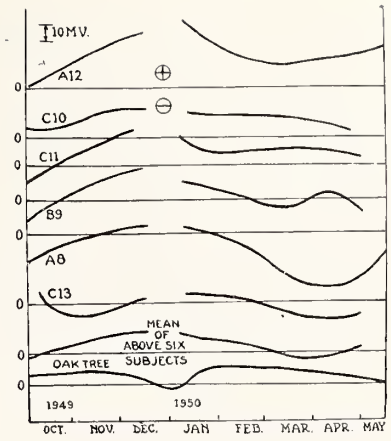


FIGURE 4
Algebraic 8-month PD trends for 6 subjects and the oak tree

with which they are in closest contact. Consequently results represent an average activity of many hundreds of cells. It is generally accepted that potentials across cell walls are due to differences in electrolyte concentrations on opposite sides of the wall. Such phenomena can therefore be explained partially by known differences in electrolyte concentration and by ionic motility across phase boundaries; yet attempts to explain these potentials on chemical grounds alone have resulted in confusion.

The exact significance of polarity is unknown; however, cyclic variations appeared more prominent when plotted with respect to signs. Negative potentials were encountered much more frequently in all subjects during late winter and early spring. Although seasonal variations in trees and humans are not directly related to altered temperatures, there may exist a correlation with mean temperatures, as this probably influences the general level of the living process.

Cycles have always had a horrid fascination for the mind of man. Some see cycles in everything; others are unwilling to see them anywhere. Folklore abounds with supposed evidence which proves the repetitive occurrence of important events, although there are too many variables and their presence in a time series is difficult to prove. However, tree records also suggest repetitive cycles, the existence of which have been observed recently in mice.

At some time in every culture, belief in the moon's influence on organic life has prevailed. As early as the 16th century, Paracelsus claimed that the insane grew worse at the dark of the moon when the moon's attraction upon the brain was believed to be

the strongest. Such beliefs were legalized in 18th century England, at which time a distinction was made between "insane," which designated the chronically and hopelessly psychotic, and "lunatic" which was applied to persons whose mental aberrations were believed to be exacerbated only by the full moon. Prior to 1808, Bethlehem hospital inmates were beaten at certain lunar periods as a prophylaxis against violence. In this connection it is of interest to point out a seeming correlation between periodic high potentials in human subjects and general unrest and disturbance on the psychiatric wards.

In the South, seasoned hunters advise coon and possum hunting at the dark of the moon and rabbit hunting during the full moon. This belief in lunar periodicity is not so surprising when one considers that tides are, in part, modified by the gravitational pull of the moon. Moreover, it has been authenticated that some nocturnal insects are influenced in many of their activities by changing lunar phases with exaggeration of response at the dark or full of the moon. Certain forms of primitive marine life in the South Pacific seem to spawn only during the full moon.

In addition, Professor Harlan T. Stetson of the Cosmic-Terrestial Research Laboratories of Massachusetts Institute of Technology has demonstrated that deep focus earthquakes may be precipitated by lunar effects on the earth's crust.[11] He also discovered a significant relationship between the field strength of radio signals received from several stations in the United States and lunar phases, which he believes may be due to periodic ionization increases of the earth's upper atmosphere due to the bombardment of solar radiations on the changing face of the moon. Increased solar radiations during years of sunspot maxima would tend to cause increased ionization of the atmosphere.[12] It is of interest, therefore, to note that tree potentials have steadily increased from 1944, when sunspot activity was minimal, to a peak in 1948-1949, the years of sunspot maxima. Since the summer of 1949, the trend has started downward as have also the sunspots.

This is a long story and the end is not in sight. Whatever else may be said, we are all electrical systems—comprising an extremely complex maze of quasielectrostatic fields.[13] As such, it would be difficult to imagine our being unaffected in measurable ways by changes in the electrical properties of the atmosphere. Regular variations in living systems, ranging from marine creatures and insects through trees to mice and men, cannot be unimportant vagaries.* Perhaps here, in the standing potentials of protoplasmic systems may be found an explanation of the lunar cycle and of the effects of the moon and sunspots on all of us. In any event, this study strongly suggests that certain and most probably all living organisms are acted upon by cosmic forces transcending local environments, but characteristic of the ordered universe of which we are all unquestionably a part.

Table 1

Monthly Means for 10 Subjects, March, 1950
(millivolts)

ARITHMETIC	SUBJECT	ALGEBRAIC
29.8	A-8	−28.7
23.1	A-12	+19.6
17.4	B-14	−14.1
17.3	B-17	−5.3
16.3	B-15	+4.3
14.9	B-16	−7.5
14.6	B-9	−3.9
16.2	C-13	−3.6
14.2	C-11	+10.1
13.8	C-10	+8.3

*Later studies at Duke University School of Medicine and the Veterans Administration Hospital of Roanoke, Virginia show that the DC voltages of psychotics, although cyclic, are considerably higher than those obtained on normal individuals[14]

Figure 1. A. M. A. Arch. Neurol. & Psychiat., 65:413-436, 1951. "Standing potential correlates of hypnosis and narcosis."

Figure 4. Yale J. Biol. & Med., 24:22-25, 1951. "Daily variations of standing potential differences in human subjects."

BIBLIOGRAPHY

1. Burr, H. S., Lane, C. T., and Nims, L. F.: A vacuum tube microvoltmeter for the measurement of bio-electric phenomena. Yale J. Biol. & Med., 9:65-76, 1936.

Burr, H. S., and Mauro, A.: Millivoltmeters. Yale J. Biol. & Med., 21:249-253, 1949.

2. Burr, H. S., and Bullock, T. H.: Steady-state potential differences in the early development of Amblystoma. Yale J. Biol. & Med., 14:51-57, 1941.

3. Burr, H. S.: Field properties of the developing frog's egg. Proc. Nat. Acad. Sc., 27:276-281, 1941.

4. Burr, H. S.: Electrical correlates of growth in corn roots. Yale J. Biol. & Med., 14:581-588, 1942.

Burr, H. S.: Electrical correlates of pure and hybrid strains of sweet corn. Proc. Nat. Acad. Sc., 29:163-166, 1943.

Nelson, O. E., Jr., and Burr, H. S.: Growth correlates of electromotive forces in maize seeds. Proc. Nat. Acad. Sc., 32:73-84, 1946.

5. Barton, D. S.: Electric corelates of the menstrual cycle in women. Yale J. Biol. & Med., 12:335-344, 1940.

Barton, D. S.: A study of temperature and electric potentials in the menstrual cycle. Yale J. Biol. & Med., 12:503-523, 1940.

Burr, H. S., Hill, R. T., and Allen, E.: Detection of ovulation in the intact rabbit. Proc. Soc. Exper. Biol. & Med., 33:109-111, 1935.

Burr, H. S., and Musselman, L. K.: Bio-electric phenomena associated with menstruation. Yale J. Biol. & Med., 9:155-158, 1936.

Burr, H. S., and Musselman, L. K.: Bio-electric correlates of the menstrual cycle in women. Am. J. Obst. & Gynec., 35:743-751, 1938.

Burr, H. S., Musselman, L. K., Barton, D. S., and Kelly, N. B.: A bio-electric record of human ovulation. Science, 86:312, 1937.

Burr, H. S., Musselman, L. K., Barton, D. S., and Kelly, N. B.: Bio-electric correlates of human ovulation. Yale J. Biol. & Med., 10:155-160, 1937.

Langman, L., and Burr, H. S.: Electrometric timing of human ovulation. Am. J. Obst. & Gynec., 44:223-230, 1942.

6. Langman, L., and Burr, H. S.: Electrometric studies in women with malignancy of cervix uteri. Science, 105:209-210, 1947.

Langman, L., and Burr, H. S.: A technique to aid in the detection of malignancy of the female genital tract. Am. J. Obst. & Gynec., 57:274-281, 1949.

7. Ravitz, L. J.: Electrometric correlates of the hypnotic state. Science, 112:341-342, 1950.

Ravitz, L. J.: Standing potential correlates of hypnosis and narcosis. A. M. A. Arch. Neurol. & Psychiat., 65:413-436, 1951.

8. Burr, H. S.: Variables in DC measurement. Yale J. Biol. & Med., 17:465-478, 1945.

9. Burr, H. S.: Moon-madness. Yale J. Biol. & Med., 16:249-256, 1944.

Burr, H. S.: Diurnal potentials in the maple tree. Yale J. Biol. & Med., 17:727-734, 1945.

Burr, H. S.: Tree potentials. Yale J. Biol. & Med., 19:311-318, 1947.

10. Saul, L. J., Davis, H., and Davis, P. A.: Correlations between electroencephalograms and the psychological organization of the individual. Tr. Am. Neurol. A., 63:167-169, 1937.

Saul, L. J., Davis, H., and Davis, P. A.: Psychologic correlations with the electroencephalogram. Psychosom. Med., 11:361-376, 1949.

11. Stetson, H. T.: Modern evidences for differential movement of certain points on the earth's surface. II. Science, 100:113-117, 1944.

12. Stetson, H. T.: Sunspots in action. New York: The Ronald Press Co., 1947.

13. Burr, H. S., and Mauro, A.: Electrostatic fields of the sciatic nerve in the frog. Yale J. Biol. & Med., 21:455-462, 1949.

14. Ravitz, L. J.: Electrodynamic field theory in psychiatry. South Med. J., (to be published). Presented at the 45th annual meeting of the Southern Medical Association, Section on Neurology and Psychiatry, Dallas, Texas, November 6, 1951.

Ravitz, L. J.: Electrocyclic and *folie à deux* phenomena in schizophrenic dizygotic twins. Annals of the Southern Psychiatric Association (to be published). Presented at the annual meeting of the Southern Psychiatric Association, Pinehurst, North Carolina, December 11, 1951.

HEREDITARY HEMORRHAGIC TELANGIECTASIA WITH PULMONARY ARTERIOVENOUS ANEURSYM

Possible Etiology and Prophylaxis

SAMUEL D. KUSHLAN, M.D., *New Haven*

The Author. *Associate Clinical Professor of Medicine, Yale University School of Medicine*

HEREDITARY hemorrhagic telangiectasia is a frequently unrecognized disease and not at all rare as hospital statistics and literature would lead one to believe. It probably accounts for many of the cases of chronic recurrent epistaxes which occur in the practice of otorhinolaryngologists and many of the patients with this disorder are also seen in emergency rooms seeking aid in stopping their almost intractable nose bleeds. Some idea of the apparent incidence of its recognition can be obtained from our record room statistics which reveal that in the New Haven unit of Grace-New Haven Community Hospital the diagnosis of hereditary hemorrhagic telangiectasia was not recorded in 143,538 admissions between 1921 and 1941. There were 5 recorded cases from 1941 to 1948, in 88,772 admissions. In contrast,

From the Department of Internal Medicine (Gastroenterology), Yale University School of Medicine, and the Medical Service of the New Haven Unit of the Grace-New Haven Community Hospital

4 cases have been recognized in 26,526 admissions between 1948 and 1950, in part related to the author's interest in this disease. The author[7] has already reported one of these cases and plans to report, in the near future, another one of the four, presenting some rather unusual features.[8] The other two of the above four cases are included in this report; one of them, D. K., has already been included in a series of 4 cases of pulmonary arteriovenous aneurysm recently reported by Lindskog and his co-workers.[12] This patient and her daughter are being reported here as an additional family afflicted with this disorder, in an effort to bring out some of the interesting interrelationships.

In 1931, Goldstein[5] published a comprehensive review of the literature, reporting 90 to 95 families with 500 to 550 persons with hereditary hemorrhagic telangiectasia. In 1946, the author noted the recording to that date of over 175 families with more than 1,000 members who had suffered from this disorder. In 1950, Garland and Anning[3] added 23 more families to make a total of 267 recorded families; 22 out of the 23 families came from one area, that of West Riding in Yorkshire. At least 3 other unreported families with this disorder, not including cases mentioned, are known to the author.

Hereditary hemorrhagic telangiectasia is characterized by repeated hemorrhages from groups of abnormally dilated capillaries and veins. The disorder is apparently inherited as a dominant characteristic, with males and females equally affected and equally transmitting the disease, as recently reaffirmed by the careful study by Garland and Anning.[4] However, there are reports of affected families in which generations have been free of the disease, only to have it recur after skipping several generations. The diagnosis is based on the criteria of definite heredity, visible telangiectases with a pathological distribution, and a tendency to bleed from these lesions.

The true nature of this condition was established in 1901 by Osler[14] who separated it from the then large group of hemorrhagic diseases of uncertain and even mysterious origin. Parkes Weber[15,16,17,18] further clarified the disease in several reports between 1904 and 1939, differentiating it from hemophilia by the absence of the sex-linked transmission and also by the well recognized tendency for epistaxis to be its first manifestation. Most of the patients also had bleeding from the skin or oral mucous membranes. The frequency of widespread bleeding from many different sources, with hemoptyses, hematemeses, melena, hematuria, and cerebral vascular accidents, was emphasized by the necropsy findings of Schuster[19] who found the telangiectases in the skin, nose, mouth, pharynx, larynx, trachea, stomach and duodenum. The delicate and easily traumatized telangiectases occur frequently and profusely on the nasal septum, accounting for the prominence of epistaxes in this diseases. Bean[1] pointed out the fact that these childhood nosebleeds often diminish later, only to recur frequently in the third and fourth decades, when the characteristic skin lesions tend to become prominent. Gastrointestinal hemorrhage usually begins in the fourth decade. The tendency for chronic blood loss may lead to a severe and incapacitating anemia; in addition, fatal hemorrhages have also been reported. Under such circumstances transfusions are usually necessary in spite of the apparent danger of transfusion reaction in these patients, particularly those with splenomegaly; however, the author's previously reported case had five transfusions without reaction.

The diagnosis of hereditary hemorrhagic telangiectasia is usually an easy one to make, since the characteristic appearance of the patient is hardly likely to be easily forgotten. The red and plethoric face is usually noted as the result of the networks of small red vessels all over the face, particularly on the cheeks; however, the mucous membranes may be quite pale as a result of the chronic blood loss and the resulting anemia. The typical skin lesion is a purplish-red spot, sharply demarcated, which may be elevated or flat. A single arterial vessel may connect with this spot, commonly called a "cherry-angioma"; if several branches are seen the lesion looks like an acquired vascular spider. Osler described three types of lesions: pinpoint spots, a spider form like the spider nevus of liver disease, and a nodular type which may gradually arise in the center of the spider. The telangiectatic networks and "cherry-angiomata" tend to be ubiquitous, internally and externally, with many lesions in each patient. The lesions are especially frequent on the palmer surfaces of the hands and fingers, the nailbeds, lips, ears, tip and dorsum of the tongue, and profuse in Kiesselbach's area on the nasal septum. They also tend to be widespread in the nasal mucosa, facial skin, buccal mucosa, floor of the mouth, scalp, conjunctivae, and fingertips. Other common sites are the ear drums, palate, pharynx, larynx, trachea, esophagus, stomach, intestines, bladder, urethra and uterus; the lesions have also been described in the brain, meninges, liver, spleen and kidneys.

The basic pathology of these telangiectases has been described by Bean and consists of a thinning of the vessel walls, particularly the muscular coat, resulting in a bulging or ballooning of the wall in a defect which may be rather extensive. Of special interest in connection with pulmonary arteriovenous aneurysm and its relationship to hereditary hemorrhagic telangiectasia is the fact that Bean also felt that the same pattern of distribution was present in hereditary hemorrhagic telangiectasia as in the glomus body or the arteriovenous anastomosis in the skin. Although there is widespread distribution of the lesions of hereditary hemorrhagic telangiectasia, it has not been associated in our minds with pulmonary arteriovenous aneurysm which has been considered a separate and distinct disorder. Moyer and Ackerman,[13] in 1948, presented the clinical, pathological, and radiologic aspects of pulmonary arteriovenous fistulae observed in two members of a family suffering from hereditary hemorrhagic telangiectasia. They noted in 15 previously reported cases of pulmonary arteriovenous aneurysm that an association with hereditary hemorrhagic telangiectasia was demonstrated in only three cases, although nine other cases had telangiectasia of the nose, face, and lips which was considered to be of a nonhereditary and nonhemorrhagic nature. In a comprehensive review of this problem in 1949, Yater and his associates[20] pointed out the increasing awareness of the occurrence of pulmonary arteriovenous aneurysms of congenital and familiar origin. They noted that these lesions have also been called pulmonary angioma, cavernous hemangioma of the lung, pulmonary arteriovenous varix or fistula. They felt it to be probable that all these benign, congenital pulmonary angiomata were another manifestation of hereditary hemorrhagic telangiectasia, with some cases merely lacking the skin and mucous membrane lesions. The reader is referred to the above two reports, together with that of Lindskog and his associates, for a detailed discussion of the clinical, pathological, radiologic, and surgical features of pulmonary arteriovenous aneurysm.

Yater and his associates noted that these pulmonary arteriovenous aneurysms are composed of a distended, thin-walled afferent artery, distended efferent veins, and an intervening vascular sac or labyrinth of distended vessels. These vascular components of the lesion apparently gradually become more dilated, degenerative changes may occur with the resulting formation of even more intercommunications and occasional rupture with hemorrhage into the lung or pleural cavity. In more than half the cases there were multiple lesions with cavities usually lined by mesothelial cells or a thin layer of connective tissue.

The clinical features of pulmonary arteriovenous aneurysm depend on the impairment in circulation caused by the passage of unoxygenated blood passing through the short-circuiting fistula or aneurysm. The resulting chronic anoxemia may lead to a compensatory polycythemia. There may be cyanosis, dyspnea, hemoptysis, weakness, precordial pain, convulsions, loss of consciousness, dizziness, diplopia, cerebrovascular accident, numbness, faintness, palpitation, headache, thick speech, and emesis; Yater and his associates listed these symptoms and felt that many of them were due to this compensatory polycythemia. Clubbing of the fingers is quite commonly associated with the cyanosis and there may be evidence of hypertrophic pulmonary osteoarthropathy. Lindskog and his associates noted the essential findings of the clinical syndrome to be cyanosis and clubbing in the presence of a normal heart together with x-ray findings of a vascular tumor in the lung fields. They felt that the central nervous system symptoms were the result of an associated polycythemia and included headache, vertigo, weakness, syncope, convulsions, paresis or paresthesia of the extremities, dysphasia and thickness of speech.

They also noted the principal physical findings in pulmonary arteriovenous aneurysm to consist of cyanosis and clubbing of the digits, although one or both of these might be absent, as in their first case. The associated findings of hereditary hemorrhagic telangiectasia have already been described above. In spite of cyanosis and dyspnea, the heart has apparently usually been found to be normal in size and shape and free of organic murmurs; blood pressure and venous pressure have also been normal. Over the aneurysm itself a continuous rough, humming murmur may be present. These authors also noted that the spleen is normal in size or questionably enlarged in these cases, in contradistinction to polycythemia vera.

The laboratory findings, as summarized by Lindskog and his associates, include the typical increase in red blood count and hemoglobin, except for those cases of repeated hemorrhage or unrelated causes of anemia. The total blood volume in those cases with an associated polycythemia is elevated with little or no increase in the plasma volume, in contrast to peripheral arteriovenous fistula. Cardiac output was not increased, venous circulation time was normal, and the blood chemistry of the blood

plasma was also essentially normal. However, the peripheral arterial oxygen saturation was usually decreased, as low as 63 per cent, and decreased further with exercise. The blood oxygen content itself might be relatively high because of the polycythemia.

In the differential diagnosis, pulmonary arteriovenous aneurysm can usually be readily differentiated from polycythemia vera, congenital heart disease, aneurysm of the pulmonary artery, and inflammatory or neoplastic lesions of the lung.

CASE 1

D. K., a 55-year old white grandmother, was admitted to the New Haven Unit of the Grace-New Haven Community Hospital on February 5, 1949 with a recurrence of a long-standing chronic osteomyelitis of the right femur, right tibia, and right fibula. This chronic osteomyelitis was first noted in 1926 and necessitated repeated hospitalizations both in this hospital and elsewhere for drainage of abscesses and removal of sequestra. She was admitted to the hospital at this itme because of headache, chills, and fever of one day's duration.

Aside from the chronic recurrent osteomyelitis she had been quite well except for one previous episode, five years before, characterized by multiple brain abscesses and meningitis with a right-sided hemiparesis from which she had recovered quite well except for a slight residual paresis; this episode was presumably related to a septicemia originating from her chronically infected right leg. The only other interesting past history was that she had had recurrent nosebleeds intermittently since childhood; these were noted to have been quite severe in 1923 when she lost as much as one half cup of blood daily. In all, the patient remembered five periods of such severe bleeding from her nose that hospitalization was necessary; on one of these occasions four years before, she had required transfusion because of the bleeding. The review of systems was not remarkable except for the above.

The family history is most interesting in that the patient's two daughters, one of whom is reported as Case 2, were noted to have scattered telangiectatic lesions on the lips, tongue, and hands.

On admission the patient was noted to have a temperature of 99.2 by mouth and this low-grade fever persisted throughout her stay, never going above 100 degrees. The other vital signs were within normal limits and continued so throughout her stay with an average blood pressure of 105/70. She did not appear very ill and complained only of a left-sided occipitoparietal headache and increasing stiffness of the neck. The skin appeared moderately dried and thickened diffusely, and small "cherry angiomata" were noted on the lips, tongue, face, fingertips, and trunk. In addition, splinter-like petechial telangiectatic lesions were noted on the lips, buccal mucous membranes, the tip of the tongue, both lower conjunctivae, the wrists, fingers, and under the nails. Examination of the fundi revealed diffusely scattered old scars bilaterally. Examination of the heart was not remarkable except for auscultation posteriorly beneath the left scapula where a loud, long, and rough systolic bruit could be easily heard in the mid-scapular line; this bruit was readily audible in this area from the seventh to the eleventh interspaces vertically and laterally to the postaxillary line and the paravertebral line in the ninth and tenth interspaces. The extremities revealed definite clubbing of the fingers and suggestive clubbing of the big toes. The right knee and ankle joints were ankylosed and there were numerous scars anteriorly and posteriorly on the right thigh and leg; the latter was one-third smaller than the left leg although the right knee was larger than the left knee. There was definite redness, heat, and tenderness of the right ankle with similar but slight changes in the left ankle. Neurological examination was within normal limits. The red blood count was 4.05 million with 10 Gm. of hemoglobin. The white blood count varied from 2900 to 5550 with an essentially normal differential count; the white blood count on previous admissions was noted to vary between 7750 and 14,200. The blood smear suggested a hypochromic but somewhat macrocytic type of anemia, and this was confirmed by study of the blood indices; the platelets appeared quite normal. The urine was normal and the N.P.N. 29 mg. per cent. Stool examinations, however, revealed a one to two plus Guaiac. Repeated blood cultures revealed no growth.

The clotting mechanism of the blood was apparently quite normal as evidenced by a normal bleeding and clotting time, a normal clot retraction time, a normal prothrombin time, and a normal red blood cell fragility. A Rumpel-Leede capillary fragility test was entirely negative with no petechiae seen after five minutes. The Gothlin petechial index was also within normal limits.

An electrocardiogram was also within normal limits. The x-ray examination of the chest revealed minimal left ventricular cardiac enlargement. The lung fields appeared clear

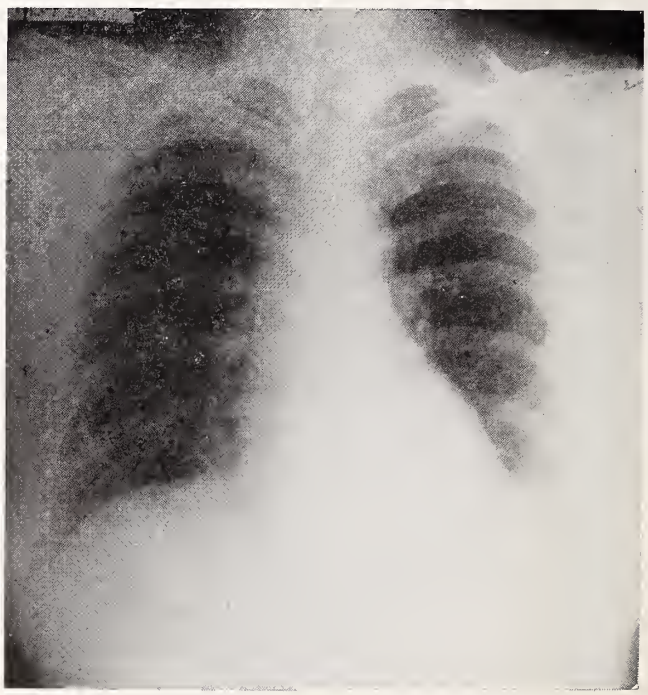


FIGURE 1

Chest x-ray revealing bilateral basilar lesions

(Courtesy of Dr. G. E. Lindskog—12—)

except for the base of the left lung field where a cluster of fairly discrete rounded soft tissue masses was noted to lie posteriorly and overlying the pulmonary vascular shadows in the lateral view; similar but smaller shadows were noted in the right cardiohepatic angle and these appeared to lie anteriorly (Figure 1). Enlarged vascular soft tissue shadows were noted running from the left lower lung field up to the left hilum. The probability of bilateral arteriovenous aneurysms (sometimes also called pulmonary arteriovenous fistula or varix) was confirmed by fluoroscopy with the Valsalva and the Mueller maneuvers and by laminographic studies (Figure 2).

Cardiac catheterization studies by Dr. Frank Gray further confirmed the diagnosis of a pulmonary arteriovenous fistula; these studies indicated that the patient's arterial saturation was 87 per cent below normal, and her pulmonary capillary blood flow about two-thirds of normal, indicating that one-third of the patient's total pulmonary blood flow



FIGURE 2

Left lateral laminogram of chest at 6 cm. showing arteriovenous aneurysms

(Courtesy of Dr. G. E. Lindskog—12—)

was being shunted through the fistulae. Dr. Gray's studies revealed a cardiac output of 6.5 liters per minute, a pulmonary capillary flow of 4.0 liters per minute, and the shunt through the fistula of 2.5 liters per minute. The right heart blood oxygen was 8.6 v.p.c. The femoral arterial saturation was 87 per cent, the femoral arterial oxygen 11.9 v.p.c., and after 100 per cent oxygen the femoral arterial saturation was 100 per cent, a deficit from the normal of 105 per cent.

Other studies revealed a completely normal spinal fluid. X-ray examination of the abdomen revealed four annular calcific areas in the right upper quadrant with every appearance of gallstones. X-ray examination of the right lower leg revealed an absent segment of the upper fibula with some periosteal new bone thickening along the medial aspect of the tibia, plus small soft tissue calcifications in the lower leg which had the appearance of phleboliths.

The patient's course in the hospital was quite uneventful and her symptoms subsided gradually. Penicillin therapy which had been begun before admission was continued in the hospital. Her epistaxes in the hospital were minimal and almost absent. It was therefore felt that the occult blood in the stools might well be coming from gastro-intestinal telangiectases; further studies of the gastro-intestinal tract were not possible during this admission because of the patient's wish to defer them until a later date.

The patient was discharged on February 15, 1949 with the diagnoses of chronic osteomyelitis of the right leg with bacteremia, hereditary hemorrhagic telangiectasia with pulmonary arteriovenous fistulae, and probable gastro-intestinal lesions to account for the melena.

COMMENT

This patient fulfills all the criteria for the diagnosis of hereditary hemorrhagic telangiectasia with a definite hereditary history, visible telangiectases with a pathologic distribution, and a tendency to bleed from the lesions. Her history was quite characteristic with nosebleeds beginning in childhood followed by the characteristic skin lesions becoming prominent in the third and fourth decades, and the apparent appearance of gastro-intestinal bleeding in middle or late middle life. The usual compensatory polycythemia seen in pulmonary arterial venous fistula was apparently masked here by the secondary anemia which was probably in turn due to both chronic blood loss and the chronic osteomyelitis. This patient therefore did not have many of the symptoms which are probably due to compensatory polycythemia such as headache, palpitation, faintness, numbness, diplopia, dizziness, thick speech, and emesis. Stereoscopic radiographic examination of the chest in 1929 revealed some thickening in both hilar regions with slight increase in markings at the left base obscuring the sulcus; this may well have represented the beginnings of the lesions, although this is quite problematical.

CASE 2

S. M., a 31-year old white married housewife, daughter of the above patient D. K., was admitted to the New Haven Unit of the Grace-New Haven Community Hospital 12-25-48 for delivery of her second child. The delivery was quite uneventful except for several hemoptyses, a nosebleed, and bleeding from the gums. She had suffered from nosebleeds intermittently ever since childhood, but she had noted relative freedom from them during the pregnancy. The patient had also noted the appearance of "blood spots" on

her skin during adolescence when she also suffered from rather severe acne; bleeding from the gums had been noted from the age of 19 and was especially marked when brushing her teeth.

The past history of this patient is interesting in that she also had osteomyelitis of the right leg as a child. She also had whooping cough as a small child, and this was followed by pneumonia; she probably also had pneumonia one year before this admission.

The patient's family history reveals, as noted above, that both her mother and her sister have hereditary hemorrhagic telangiectasia. The patient's father is also said to have small red raised "spots" scattered over his body and to have intermittent bleeding from the gums.

On examination the patient's vital signs were normal with blood pressure 110/70. Multiple small "cherry angiomata" were noted on the patient's back with a few on the anterior trunk; these were also noted on the lips, tongue, gums, conjunctivae, nailbeds, and networks of what appear to be dilated capillaries were noted in the nose. Examination of the lungs revealed dullness with suppression of breath sounds and a few moist rales at the left base.

The serology was negative. The red blood count varied from 5.38 million to 6 million with 14-15.5 Gm. of hemoglobin. The white blood count varied from 9,300 to 26,200 with varying degrees of polymorphonuclear leukocytosis. The blood smear was within normal limits and did not reveal any abnormal cells; the platelets appeared quite normal and adequate in distribution. The bleeding and clotting times were normal, but the prothrombin time was 70 per cent of normal. A Rumpel-Leede tourniquet test was negative. The stools were negative for occult blood.

The urine was within normal limits. Examinations of the sputum were negative for tuberculosis or other pathogenic organisms; a tuberculin test was also negative. Blood cultures revealed no growth. Examination of the blood for cold agglutinins was also negative.

X-ray examination of the chest strongly suggested bronchiectasis and atelectasis of the left lower lobe, and this was confirmed by bronchoscopy and bronchograms (Figure 3).

During her stay in the hospital the patient had a short period of delirium with confusion, restlessness, twitching, and semi-stuporous periods; this was felt to be due to a combination of factors including cerebral anoxia, a reaction to sedative medication, together with her hemorrhage and the preceding train of events. An electroencephalogram revealed paroxysmal slow waves as seen in patients with epilepsy or a deep brain tumor; however, there was no confirmatory evidence clinically.

The patient was discharged on January 13, 1949, to return later for a left lower lobectomy. She was re-admitted the following evening because of a massive hemoptysis which occurred during postural drainage. She was rather cyanotic and in obvious respiratory distress and had signs of atelectasis over the left lower lobe. The patient responded well to oxygen therapy and transfusion, although her blood count had fallen to only 4.45 million red blood cells with 13 Gm. of hemoglobin. The patient's fingers were noted to be slightly clubbed, and this with the known polycythemia, the hemoptyses, and the electroencephalographic changes of the previous admission, all raised the question of the presence of a hemangioma of the lung with a brain abscess, often associated with a lung hemangioma.

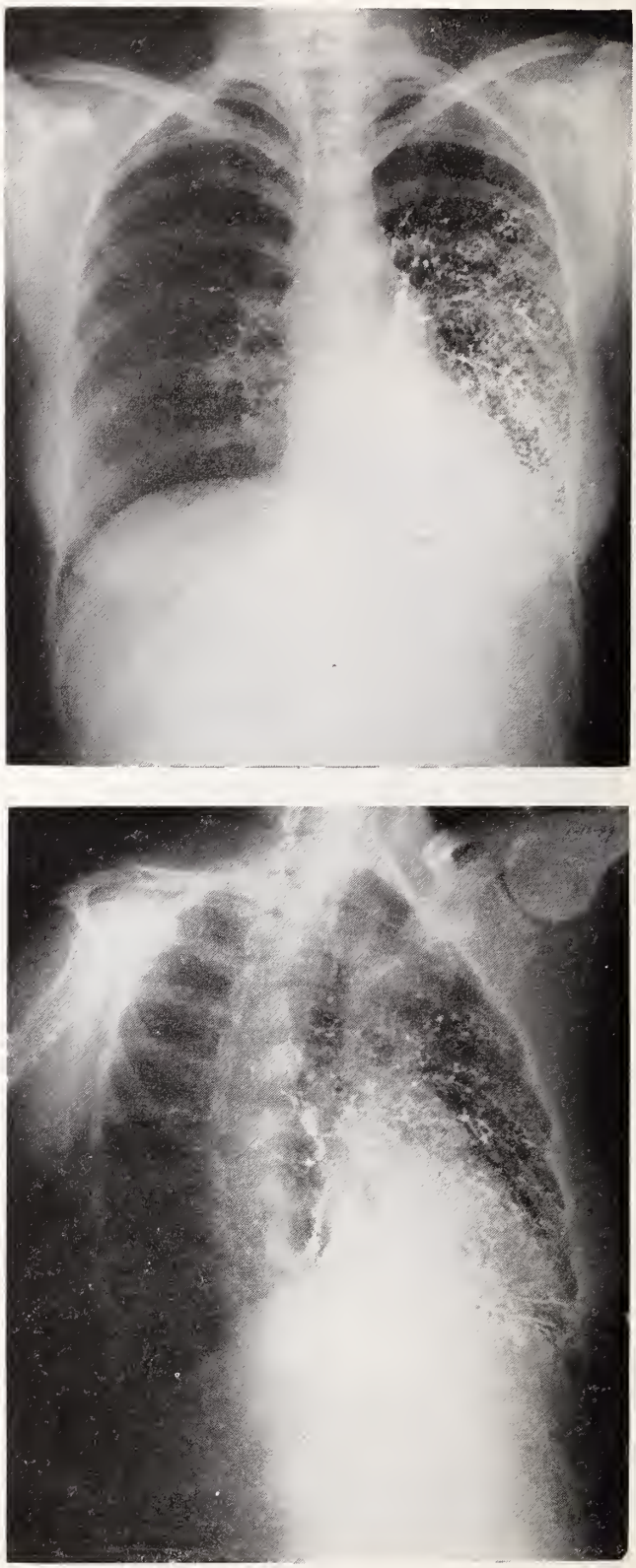


FIGURE 3, A AND B
P.A. and R.A.O. Bronchograms revealing bronchiectasis and atelectasis of left lower lobe

On this admission the bleeding time, clotting time, clot retraction time, and the prothrombin time were all found to be within normal limits. The platelet count was also normal. Liver function studies were within normal limits. Oxygen studies of the arterial blood revealed a 90 per cent saturation. There was no evidence of increased capillary fragility, the Gothlin petechial index being quite negative.

X-ray examination confirmed the clinical impression of atelectasis of the left upper lobe in addition to the previous findings of atelectasis and bronchiectasis of the left lower lobe. Efforts to aspirate blood and mucus plugs to clear up the atelectasis resulted only in markedly increased bleeding, and it was necessary to allow spontaneous clearing of the atelectasis.

Left lower lobectomy was done on January 31, 1949. Careful pathological study of this excised lobe, including serial sections, revealed bronchiectasis and organizing pneumonitis; there was no evidence whatsoever of any angiomata or arteriovenous fistulae. The postoperative course was uneventful except for several thoracenteses which were required to control the postoperative pleural effusion; there was also a complicating phlebothrombosis of the left leg which was relatively benign in its course. She was discharged on February 18, 1949 with the diagnoses of left lower lobe bronchiectasis with left lower lobectomy, and hereditary hemorrhagic telangiectasia.

The patient was followed in the outpatient department. Her nosebleeds continued to be very mild with only one or two drops of blood every day or two. Several chest x-ray examinations revealed only the expected postoperative findings with partial resection of the left 7th rib and a left lower lobectomy; residual lipiodol was still present in the left lung. The patient continued to be quite apprehensive and anxious, complaining of severe headaches, dizziness, occasional nausea, weakness, faintness, palpitation, and had episodes suggesting hysteria and emotional instability. Neurological examination and an examination of the spinal fluid were entirely within normal limits.

COMMENT

This patient also fulfilled all the criteria for a diagnosis of hereditary hemorrhagic telangiectasia. The chronological occurrence of her nosebleeds, gumbleeds, and telangiectatic lesions is also quite characteristic. Her family history is somewhat unusual in that both her father and her mother have the disease, although there may be some question about its occurrence in the father. Although it is undoubtedly coincidental, it is most interesting that the patient also had osteomyelitis of the same leg as her mother, although the patient's course was a much more benign one. The clinical impression at one time that there might be an hemangioma of the lung in this patient is most interesting, and although it was proved not to be present at the time of operation, one might speculate that there were telangiectatic lesions in this lung which contributed to the final picture in the lung; the same lung in her mother was the site of the major pulmonary arteriovenous aneurysm. The marked emotional instability and many of the other symptoms seen after the patient's last discharge and while she was being followed as an outpatient are probably related more to her compensatory polycythemia with central nervous system symptoms; her toxic psychosis may also have been partly on the same basis.

DISCUSSION

These cases of hereditary hemorrhagic telangiectasia in a mother and her daughter are of particular interest because of the associated occurrence of pulmonary arteriovenous fistulae in the mother and bronchiectasis in the daughter. Although the occurrence of pulmonary arteriovenous fistula as another form or variant of hereditary hemorrhagic telangiectasia seems well established, the relationship of the daughter's bronchiectasis to her generalized vascular disease is, of course, not at all clear and possibly without any association. In their report of 23 additional families afflicted with hereditary hemorrhagic telangiectasia, Garland and Anning[3] found arteriovenous aneurysm of the lung present in two of the families reported. It is also of great interest that both of the patients reported in this paper suffered from osteomyelitis of the right leg; although this could well be coincidence, it may well be more closely related in some way to the generalized vascular disease present in both patients.

Although the therapy for pulmonary arteriovenous aneurysm seems to be quite definitely established as surgical excision of the affected lobe, the therapy of the underlying and associated hereditary hemorrhagic telangiectasia is much less specific. The multitude of treatments, advocated or actually tried in connection with the latter disorder, indicates the absence of any specific remedy. Therapy, on the whole, has been very difficult and unsatisfactory and has included electrolysis, x-ray or radium, microinjection of sclerosing solutions, and parenteral moccasin venom. The only medication of any proven value has been the administration of all iron in full and continued dosage, combined with an adequate high protein and high vitamin diet, to combat the chronic blood loss and the chronic secondary anemia. In addition, it is important to avoid and reduce trauma to the thin walled vascular lesions; increased intra-abdominal congestion brought about by straining or excessive coughing should be avoided. In the pres-

ence of severe bleeding transfusions are life saving; a mortality rate of about 4 per cent has resulted from severe hemorrhage in this disorder.

Any prevention or correction of the basic vascular fault obviously depends upon the discovery of the basic cause of the fault. The basic pathology of these telangiectases is a thinning and bulging of a vessel wall which may be of single endothelial cell thickness, resulting in a capillary-like vessel. Lindheimer and his associates[11] pointed out the fact that vitamin "P" seems essential in maintaining normal vascular endothelial strength together with improved capillary resistance in various conditions, whether of known dietary origin or not. Griffith and his associates[6] have shown that rutin is similar to vitamin "P" both in structure and action. In view of the above, the author felt that rutin might well be beneficial in hereditary hemorrhagic telangiectasia and the use of rutin in this disorder was first reported by the author in 1946. Further data on the use of rutin in this disorder are available in the literature; some interesting aspects of rutin therapy in this connection are included in another report.[8] Although the many reports regarding the use of rutin in this disorder have been conflicting, only further investigation will clarify this. It would seem quite logical to attempt to decrease the fragility and increase the strength of the wall of these telangiectases by means of rutin or any similar substance.

A new and fascinating approach to the basic problem of this disorder and the role of rutin is related to the inhibiting effect of rutin on the action of the spreading factor, hyaluronidase, as demonstrated in vitro by Beiler and Martin[2] and in animals by Levitan.[9,10] On the basis of his animal experiments, Levitan has suggested that the wide distribution of hyaluronidase normally maintains tissue and capillary permeability and that its "overfunction" is prevented by vitamin "P." A deficiency of vitamin "P" would then lead to an excessive action of hyaluronidase with weakening of all the ground substance and abnormal increase in the permeability of tissue as well as capillaries and with weakening of arterial walls. Levitan went so far as to postulate that the stabilizing influence of rutin and ground substance might act on the entire vascular system and not just on the capillaries. He further postulated that the weakening of the ground substance by vitamin "P" deficiency might be the predisposing factor for the development of degenerative and infectious diseases. Further, a deficiency of vitamin "P" or related substances, carrying out the above postulates, might well be the factor leading to the development of telangiectases in hereditary hemorrhagic telangiectasia.

It seems to follow that it would be desirable to attempt prophylactic therapy in the form of the administration of rutin or related substances to the children born of parents afflicted with hereditary hemorrhagic telangiectasia. It might even be preferable to begin such therapy by administering the medication to the expectant mother throughout the course of her pregnancy, in the hope that telangiectatic lesions in the fetus might thus be prevented; such therapy would be effective only if the drug passed through the placental circulation into that of the fetus. The potential benefits of such prophylactic therapy in this disease and in related degenerative vascular disorders seem most promising.

SUMMARY

1. Two additional cases of hereditary hemorrhagic telangiectasia are reported in a mother and her daughter.

2. Pulmonary arteriovenous aneurysms, apparently a variant of hereditary hemorrhagic telangiectasia, were also present in the mother who also had osteomyelitis of the right leg.

3. Bronchiectasis without demonstrable telangiectatic lesions was present in the daughter who also had had osteomyelitis of the right leg.

4. Possible theories regarding the pathogenesis of hereditary hemorrhagic telangiectasia are discussed together with the resulting prophylactic and therapeutic implications.

5. The clinical importance and nature of hereditary hemorrhagic telangiectasia are discussed and warrant increased recognition of this disease.

REFERENCES

1. Bean, W. B.: The Cutaneous Arterial Spider: A Survey. Medicine, 24:243-331, 1945.

2. Beiler, J. M., and Martin, M. J.: Inhibitory Action of Vitamin P Compounds on Hyalurondase. J. Biol. Chem., 171:507-511, 1947.

3. Garland, H. G., and Anning, S. T.: Hereditary Hemorrhagic Telangiectasia. Br. Med. Jour. 1:700-701, 1950.

4. Idem: Hereditary Hemorrhagic Telangiectasia: A Genetic and Bibliographical Study. Br. Jour. Derm. and Syph., 62:289-310, 1950.

5. Goldstein, H. W.: Goldstein's Heredofamilial Angiomatosis with Recurring Familial Hemorrhages. Arch. Int. Med., 48:836-865, 1931.

6. Griffith, J. A., Jr., Couch, J. F., and Lindauer, M. A.: Effect of Rutin on Increased Capillary Fragility in Man. Proc. Soc. Exp. Biol. Med., 55:228-229, 1944.

7. Kushlan, S. D.: Gastro-Intestinal Bleeding in Hereditary

Hemorrhagic Telangiectasia. Historical Review and Case Report with Gastroscopic Findings and Rutin Therapy. Gastroenterology 7:199-212, 1946.

8. Kushlan, S. D.: Hereditary Hemorrhagic Telangiectasia—Occurrence in the Negro—Relation to Blood Group—Effects of Rutin and Dicumarol Therapy. To be Published.

9. Levitan, B. A.: Inhibition of Testicular Hyaluronidase Activity by Rutin. Proc. Soc. Exp. Biol. Med., 68:566-568, 1948.

10. Idem: Action of Vitamin P on the Stability of Connective Tissue Ground Substance. Am. Jour. Physiology, 157:422-428, 1949.

11. Lindheimer, G. T., Hinman, W. F., and Holliday, E. G.: Function and Occurrence of Citrin ("vitamin P"). J. Am. Diet. Assoc., 18:503-507, 1942.

12. Lindskog, G. E., Liebow, A., Kausel, H., and Janzen, A.: Pulmonary Arteriovenous Aneurysm. Ann. Surg., 132: 591-610, 1950.

13. Moyer, J. H., and Ackerman, A. J.: Hereditary Hemorrhagic Telangiectases Associated with Pulmonary Arteriovenous Fistula in Two Members of a Family. Ann. Int. Med., 29:775-802, 1948.

14. Osler, W.: On a Family Form of Recurring Epistaxis with Multiple Telangiectases of the Skin and Mucous Membranes. Bull. Johns Hopkins Hosp., 12:333-337, 1901.

15. Parkes, Weber, F.: A Note on Cutaneous Telangiectases and their Etiology. Edinburgh Med. Jour., 15:346-349, 1904.

16. Idem: Multiple Hereditary Developmental Angiomata (Telangiectases) of the Skin and Mucous Membranes Associated with Recurring Hemorrhages. Lancet, 2:160-162, 1907.

17. Idem: Hemorrhagic Telangiectasis of the Osler Type. Br. Jour. Derm., 48:182-193, 1936.

18. Idem: Telangiectatic Dysplasia. Proc. Royal Soc. Med., 32:1393-1396, 1939.

19. Schuster, N. H.: Familial Hemorrhagic Telangiectasia Associated with Multiple Aneurysms of the Splenic Artery. J. Path. & Bact., 44:29-39, 1937.

20. Yater, W. M., Finnegan, J., and Giffin, H. M.: Pulmonary Arteriovenous Fistula, (Varix)—Review of the Literature and Report of Two Cases. J.A.M.A., 141:581-589, 1949.

ACUTE DISSEMINATED LUPUS ERYTHEMATOSUS IN A THIRTEEN YEAR OLD WHITE MALE

Demonstration of the "L. E." Cell and Results of Cortisone Therapy

Nicholas H. Bentas, M.D., Jean A. Spencer, M.D. and Sidney L. Penner, M.D., *Bridgeport*

Dr. Bentas. *Chief Medical Resident, Bridgeport Hospital, Bridgeport, Connecticut*

Dr. Spencer. *Medical Intern, Bridgeport Hospital, Bridgeport, Connecticut*

Dr. Penner. *Associate Visiting Physician, Bridgeport Hospital, Bridgeport, Connecticut*

(With the technical assistance of Barbara Hedberg, B.S.)

Acute disseminated lupus erythematous is usually considered a disease of adult females. In recent years, however, seventeen to twenty-seven per cent of the cases have been reported in males.[1] The youngest male proven to have had acute disseminated lupus erythematosus was a twelve year old negro reported by Pastor, Sloane, and Goldburgh.[2]

This is a report of a thirteen year old white male with acute disseminated lupus erythematosus. In this case, the "L. E." cell which was first noted by Hargraves in the bone marrow of patients with acute disseminated lupus erythematosus, was also demonstrated, and substantiated the diagnosis.

CASE REPORT

The patient was a thirteen year old white male of Russian descent who was admitted to Bridgeport Hospital on April 28, 1951. He had been perfectly well until September, 1950, when he developed painful, swollen lymph glands in his right groin. He remained in bed for three days and was well again until the last week of October, 1950, when his thighs became sore. This soreness became progressively worse, and in December, 1950, also extended to the legs. About this time he developed easy fatigue and noted that the muscles of his entire body were tender. During the middle of December, 1950, first his fingers and knuckles and later his left knee became swollen and tender.

At that time, examination disclosed a grade 2 systolic murmur at the cardic apex, a palpable spleen, and purpuric areas over the ankles. The diagnosis of acute rheumatic fever was made and hospitalization was advised. The patient was admitted to another hospital where he stayed eleven days. Here he had a fever of 102° for one day. Laboratory tests showed no anemia, but leukopenia, albuminuria and

microscopic hematuria were found. His electrocardiogram showed a PR interval of 0.20 seconds which was considered abnormally prolonged. He was treated with cortisone, receiving a total of 975 mg., and was discharged improved. He was kept on a maintenance dose of cortisone at home until March, 1951. During the latter part of March, 1951, he had fever and chills for several days. He then developed anorexia with several episodes of nausea and vomiting and had two brief episodes of pain in the lower left chest. The last week of April he developed tender swollen ankles. He became increasing anemic and was referred to this hospital for transfusion.

PAST ILLNESSES

The patient had had whooping cough and acute bronchitis. At the age of seven he had measles. When he was eight years old he had a tonsillectomy and in the same year following an injury he developed severe tetanus for which he was given 500,000 units of tetanus antitoxin. He had had frequent sore throats every winter.

FAMILY HISTORY

The father has rheumatism. A paternal uncle has rheumatoid arthritis.

PHYSICAL EXAMINATION

The physical examination revealed a thin, intelligent, and cooperative white boy who looked younger than his given age and appeared chronically ill. The blood pressure was 118 systolic, 69 diastolic, the pulse rate 120, the temperature 100° F. (R), and the respirations 20 per minute. There was a dusky, erythematous and scaling, butterfly rash over the nose and cheeks. There were no other skin lesions at this time. The eyes and fundi were normal. The tympanic membranes were thickened bilaterally. The pharyngeal wall was slightly injected. The lungs were clear. The heart was thought to be enlarged to the left, on percussion. There was a soft nontransmitted systolic apical murmur and a loud, harsh, systolic pulmonic murmur transmitted to the left shoulder. No accentuation of the mitral first sound could be brought out by exercise and there were no diastolic murmurs. The liver was smooth, nontender, and palpable 1 cm. below the right costal margin. The spleen was palpable 3 cm. below the left costal margin. Neurological examination was normal. The fingers were long and thin, but fusiform in shape, the skin over them being shiny and slightly tense. The joints of the fingers were dusky. There were dusky, dry, scaling patches over the dorsum of the feet and ankles. The ankles were slightly swollen, but did not pit, and were only slightly tender. There were shotty lymph nodes in both inguinal regions and one pea-sized lymph node in the left axilla.

LABORATORY FINDINGS ON ADMISSION

The red blood cell count was 2,440,000; the hemoglobin, 7.6 Gm., (50.6 per cent); white blood cell count was 4,200; platelets, 246,000; the sedimentation rate was 34 mm./hr. (uncorrected); the blood urea nitrogen was 23 mgm. per cent; the total serum protein, 6.84 Gm. per cent; albumin, 3.63 and globulin, 3.20. The total serum cholesterol was 120 mgm. per cent; the free cholesterol, 41.3 mgm. per cent. The blood Hinton was negative. Urinalysis revealed a specific gravity of 1.014; albumin 400 mgm. per cent (4 plus), sugar 0, red blood cells 2 plus, white blood cells 2 plus, casts 4 plus, and bacteria 4 plus.

The electrocardiogram showed a PR interval of 0.2 seconds which was considered prolonged for his age and for the rate of 120, but was otherwise normal.

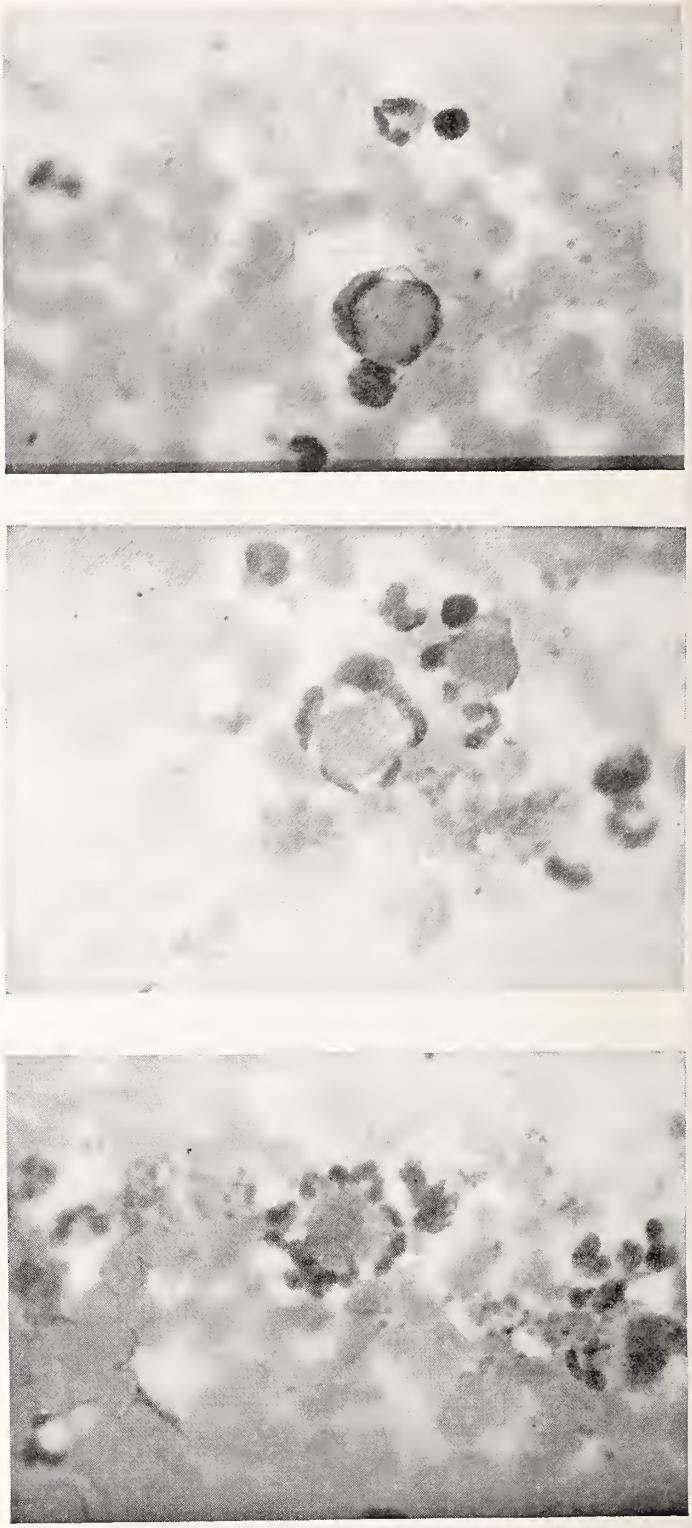


FIGURE 1
The "L. E." Cell Rosette (Bentas et al)
Magnification 10 × 97 (oil immersion) enlarged 5 times

The radiographic examination showed no evidence of parenchymal infiltration or pleural pathology. The transverse diameter of the heart was 12.2 cm., and the internal diameter of the chest was 25.6 cm. The heart was within normal limits as to size and contour.

The admission diagnosis was acute disseminated lupus erythematosus.

COURSE IN HOSPITAL

During the first ten days the symptoms remained unchanged although the butterfly rash became less distinct. The temperature fluctuated between 99° and 101° F. (R) Two days after admission, a sternal bone marrow aspiration was performed and interpreted as being normal. No "L. E." cells could be demonstrated in the buffy coat of the bone marrow. On the same day, the buffy coat of the patient's heparinized peripheral blood was negative for "L. E." cells. Three blood cultures were sterile. The blood count remained unchanged and the patient was given a transfusion of 500 cc. (1 unit) of whole blood. On only one occasion could uroporphyrins, but not hematoporphyrins, be found. Otherwise, the urinary findings were essentially the same.

During the next four days, the patient had become clinically worse with a temperature of 102° and 103° F. (R) daily. The patient was given two more units of blood. On the eleventh hospital day we again failed to demonstrate the "L. E." cells using the patient's plasma and the bone marrow of a normal patient.[5] We were also unable to find the "L. E." cells using the patient's blood mixed with normal blood.[6] The Widal and Huddleson agglutinations were negative.

On the fourteenth hospital day, cortisone therapy was instituted. The patient was given 100 mgm. i. m. every eight hours for three doses, 100 mgm. every twelve hours for two doses, and 100 mgm. daily thereafter. The patient was now placed on a diet containing less than 0.5 Gm. of sodium chloride daily. Before treatment was started, the absolute eosinophile count was 44, the blood urea nitrogen was 46 mgm. per cent and 42 per cent of the phenolsulfonphthalein dye was excreted within two hours.

On the sixteenth day, the second day of cortisone treatment, the "L. E." cell was first demonstrated in the peripheral blood using the method described by Moffatt, Barnes, and Weiss[6] (Figure 1.). At this time the patient was still acutely ill, although afebrile.

Within the first ten days of treatment the patient was subjectively improved. However, he developed a moon face and his blood pressure rose to 140 systolic, 90 diastolic. His weight remained stable. The absolute eosinophile count dropped to zero. Although the urinalysis remained unchanged, the blood urea nitrogen fell to 18 mgm. per cent. After receiving a fourth unit of blood, the red blood cell count rose to 4,170,000 and the erythrocyte sedimentation rate, to 30 mm./hr., uncorrected. No "L. E." cells could be found in the peripheral blood now.

On the fifteenth day of treatment with cortisone, petechiae appeared on the feet and ankles. The bleeding, clotting, and prothrombin times were all within normal limits. The platelet count was 410,000. The Rumpel-Leeds phenomenon showed increased capillary fragility after five minutes. The blood urea nitrogen was 29 mgm. per cent.

By the seventeenth day of treatment the patient had developed acne of the chin and the moon face became more pronounced. He had gained six pounds of weight and his blood pressure varied between 130 and 150 systolic, 80 and 110 diastolic. The cortisone was decreased to 100 mgm. intramuscularly every other day. The serum sodium was 360 mgm. per cent or 138 Meq.

During the third week of treatment, the petechiae persisted. The red blood count fell to 3,380,000 and the erythrocyte sedimentation rate to 23 mm./hr. uncorrected. The blood urea nitrogen rose to 32 mgm. per cent. The urinary findings remained the same, but the albuminuria increased to 1000 mgm. per cent. The serum sodium was 306 mgm. per cent or 133 meq. The rash was still faintly visible. An exudate was now seen in the left fundus. The pulmonic systolic murmur was still present, but other cardic murmurs could not be heard. The blood pressure now never fell below 140 systolic, 90 diastolic, and the total weight gain was twelve pounds. On the twenty-sixth day of treatment "L. E." cells were found in nonheparinized blood according to the method described by Eppes and Ludovic.[7]

During the fourth and fifth weeks of therapy, the blood pressure gradually rose to 180 systolic, 126 diastolic, and the phenolsulfonthalein excretion fell to 27 per cent in two hours. New exudates appeared in both fundi. The administration of cortisone was changed to 50 mgm. orally, daily. No peripheral edema was ever demonstrable. At the end of this week, the parents insisted that the patient be discharged.

Later, we heard that the patient had been admitted to another hospital on July 14, 1951, and had expired the next day. Permission for an autopsy could not be obtained.

DISCUSSION

The diagnosis of acute disseminated lupus erythematosus can be made when certain cardinal features are present. These include: (1) The erythematous skin lesion found in typical butterfly pattern over the face; (2) Constitutional symptoms which may be insignificant at first and which may later become severe or disappear; (3) Arthralgia; (4) Kidney involvement; (5) Depression of the bone marrow; (6) Serous effusions and (7) Predominant occurrence in females. At times the diagnosis has been made in the absence of one or more of these major diagnostic criteria; as in the absence of the skin lesions which give the condition its name. Frequently the diagnosis was not suspected until autopsy. However, in 1948, an important aid to the in vivo diagnosis of acute disseminated lupus erythematosus arose from the description by Hargraves et al[3] of the "L. E." cell and the "L. E." cell rosette in the bone marrow of patients with this disease. The diagnostic value of the "L. E." cell in the bone marrow was

first emphasized by Haserick and Sundberg in 1948.[4] Since then, other methods have been devised to demonstrate the "L. E." cell phenomenon in both the plasma and the peripheral blood. Most of the subsequent literature indicates that demonstration of the "L. E." cell is very strong evidence of acute disseminated lupus erythematosus. In this case, the presence of the "L. E." cell in the peripheral blood gave further support to the diagnosis of disseminated lupus erythematosus which had been questioned because of the sex and age of the patient, and because of the evanescent nature of the rash on the face.

Our patient was symptomatically better while receiving cortisone. Hypertension and retinal exudates developed while on cortisone therapy, and the increasing albuminuria and the marked fall in the phenolsulfonthalein excretion by the kidneys indicated progression of the renal damage. Haserick, Corcoran and Dustan[8] found that even massive doses of cortisone did not alter the urinary abnormalities. This has been the experience of many other investigators who have found that while the drug may be life saving during an acute crisis, it is powerless to prevent the insidious progression of the disease.

SUMMARY

A case of acute disseminated lupus erythematosus in a thirteen year old, white male is presented; one of the two youngest white males to have had this disease.[9] The diagnosis was substantiated by demonstrating the "L. E." cell in the peripheral blood. Although the patient was symptomatically improved by cortisone therapy, the disease progressed and renal changes became more marked.[9,10,11,12]

BIBLIOGRAPHY

1. Disseminated Lupus Erythematosus in the Male. Medical News Letter, U. S. N. Vol. 17: 15-17. February 13, 1951.

2. Pastor, B. H., Sloane, N. G., Goldburgh, H. L.: Disseminated Lupus Erythematosus in the Male. Report of Five Cases. New England Jour. of Med., Vol. 244:81. January 18, 1951.

3. Hargraves, M. M., Richmond, H., Morton, R. J.: Presentation of Two Bone Marrow Elements, "Tart" Cell and "L. E." Cell. Proceedings of the Staff Meetings, Mayo Clinic. Vol. 23:25-28. January 21, 1948.

4. Haserick, J. R., and Sundberg, R. D.: Bone Marrow as Diagnostic Aid in Acute Disseminated Lupus Erythematosus; Report on Hargraves' "L. E." Cell. Journ. Investigative Dermatology, Vol. 11:209-213. September 1948.

5. Hargraves, M. M.: Production in vitro of the "L. E." Cell Phenomenon. Use of Normal Bone Marrow Elements and Blood Plasma from Patients with Acute Disseminated Lupus Erythematosus. Proceedings of the Staff Meeting, Mayo Clinic. Vol. 24: 234-237. April 27, 1949.

6. Moffatt, T. W., Barnes, S. S., Weiss, R. S.: Induction of the "L. E." Cell (Hargraves) in Normal Peripheral Blood. Journ. Investigative Dermatology. Vol. 14:153-156. March, 1950.

7. Eppes, W., and Ludovic, E. Blood: Methods: Demonstration of the "L. E." Cell Without Use of Anticoagulents. The Journ. Hematology. Vol. 6:466-469. May, 1951.

8. Haserick, J. R., Corcoran, A. C., and Dustan, H.: ACTH and Cortisone in the Acute Crisis of Systemic Lupus Erythematosus. Journ. A. M. A. Vol. 146: No. 7 643-645. June 11, 1951.

9. Baehr, G., Soffer, L. J.: Treatment of Disseminated Lupus Erythematosus with Cortisone and ACTH. Amer. Practitioner. Vol. 1:883-884. 1951.

10. Hersch, P. S., Kendell, E. C., Slocomb, C. H., Polley, H. H.: Effects of Cortisone and ACTH. Arch. Medicine. Vol. 85:545-666. April, 1950.

11. Plotz, C. M., Howes, E. L., Blunt, J. W., Meyer, K., Ragan, C.: The Effect of Cortisone and ACTH on Disseminated Lupus Erythematosus and Mesenchymal Tissue. Arch. Dermatology Syphilology. Vol. 61:887-924. 1950.

12. Irons, E. N., Ayer, J. P., Brown, R. G., Armstrong, S. H., Jr.: Effects of ACTH and Cortisone on Diffuse Collagen Disease and Chronic Dermatoses. Journ. A. M. A. Vol. 145:861-869. March 24, 1951.

ROSACEA WITH COMPLICATIONS: CASE REPORT

EUGENE F. KALMAN, M.D., *Bridgeport*

THE origin of rosacea is shrouded in mystery. Various theories have been promulgated and treatments have been recommended accordingly with disappointing results. Among the theories are hypo- or avitaminosis of the various vitamins, low gastric acidity, endocrine disturbances, and in the past, drinking. Of course the medical profession has been aware for a long time that alcohol has nothing to do with this condition, but the laity still believes it. Patients, after many unsuccessful trials at therapy, usually see the physician when complications occur, namely, acneform, pustulous pyoderma and eye complications. These usually include blepharitis, conjunctivitis and keratitis.

The patient, W. C., is an 80 year old male whom I have known about 12 years and all these years he has had rosacea and a sizable rhinophyma. He has been well except for senile arteriosclerosis commensurate with his age and a moderately well behaving arteriosclerotic heart. Until one year ago he was gainfully employed, but for the past year he has not done any work.

He came to the office with a flareup of the rosacea, pustulous acneform eruptions on both cheeks, and blepharitis with a fair amount of mattering on the lids, and conjunctivitis. Antibiotic eye drops and ointment were prescribed (aureomycin) and the patient was seen three days later. There was no improvement. Three daily injections of penicillin suspension, 450,000 units each, were given and local treatment was continued. After three days there was improvement and the injections were discontinued. The topical treatment was continued as before.

One week later I had to see the patient at home. He was quite uncomfortable, there was a severe worsening of the condition, with the addition of keratitis. There was a turbidity of the cornea, with severe pain and photophobia.

The topical treatment was discontinued now, because there was a question of possible allergy to the medication although this was probably remote. Warm boric compresses were applied and cortisone eye drops were given. There was no improvement; if anything, it was worse. Temperature was 100.6 and there was much pain.

Now all the local medications were discontinued. Penicillin 600,000 units and 1 Gm. streptomycin were given daily intramuscularly and 20 units of ACTH in gel (in the two buttocks). The improvement was immediate; in 24 hours the pain and inflammation was less and the patient felt much better, temperature was normal. In 48 hours he was very much improved. Six such treatments were given altogether and at the time of the last one he was well. The face was clear, the eyes including the cornea perfectly normal. No medication of any kind was given thereafter. The patient has been well since and his rosacea is better than it has been for a long time. His blood pressure, which was 160/95, did not change during the treatment.

COMMENT

The dramatic response of this patient to ACTH and probably the parenteral antibiotics is worth noting. The patient has been well now eight months.

OUR FADING HERITAGE

HARTWELL G. THOMPSON, M.D., *Hartford*

This little discourse was not written for delivery today. It was written in response to urgent prompting by deep-seated convictions with no thought as to where or when, or whether it ever would be read.

A few months ago, a young surgeon, who is a friend of mine, was driven home from a gathering of surgeons in a neighboring city by another young surgeon of approximately my friend's age. His companion quite obviously had been infuriated by the discussion of Voluntary Medical Insurance Plan fees which had arisen at the meeting. As soon as both men were seated in his beautiful new Cadillac, the owner fulminated, "I'm going to get mine now! Nobody is going to tell me what the hell I'll charge!"

My friend was silent. Stunned by the abrupt brutality of the announcement, his sensitive nature recoiled from the blunt disclosure of the indurated dispositon of his companion. The degrading and callous expression could not have been voiced before a more unwilling and unsympathetic listener, for my young friend had been inspired to study medicine by his love and admiration for an elderly family doctor of his boyhood.

Shocked by the bitter self revealment of the driver, my friend recalled again, as he had on countless occasions from grammar school through surgical residency, the three days of constant attendance given without thought of payment by this kind old gentleman of medicine in the successful effort to save his, the young surgeon's life when he was a small boy. Vividly he envisioned the coldwater flat of his childhood where the unseeking elderly physician had lived for those three days, nursing him, bolstering his parents' courage, and, when their funds were exhausted, advancing small sums for the necessities. In that experience my friend's ambition was forged. He, too, would be a doctor; skillful, kind, patient, charitable. From that goal he has never deviated. Now an established surgeon of great skill, judgment and daring, he remembers always and exhibits the patience, compassion, and charity of his early idol. He charges amply those who can well afford his services. He never gouges the poor. He is fair in his dealings with the group between. In short, he is like the great majority of medical men, like you who are here today. Like you, he regards the license to practice surgery as just that—not a license for licentiousness.

What bitter strain has been grafted on to the tree of medical education evolution that such sour fruit as that other conceited, cold-blooded, arrogant and heartless young surgeon could be a part of the harvest? How can the endless repetition of that harvest be avoided; by what process of selection for medical training? How can the ruthless greed infiltrating into medicine be controlled? Such were his troubled thoughts during that drive; such are, and have been yours.

Let me take you back with me to a massive shoulder of the Great Smokies in Tennessee on a very hot day in early June of 1951. It was 1:30 in the afternoon. We were off the usual tourist route. Even in the mountains the day was uncomfortably hot. We were hungry and thirsty but in our seemingly never ending climb with the abrupt mountain wall on our left and the deep ravines on our right, we could find no space off the road to park our car. Finally, the road widened on a bend and there on the right, set back about eighty feet from the road, stood a little weather beaten country church. Gratefully we parked our car in the shade of the two tall pines which stood before the church.

It was not such a country church as one sees in New England. It's white paint was lifeless and peeling. The bell rope hung straight down from the tiny belfry into the center of the church. The pews were old and discouraged. The floor was of rough and

Presented before the New England Obstetrical and Gynecological Society, Hartford, April 23, 1952

uneven pine boards. The lectern was made of red brick with a slanting slab of polished stone to support the Bible. It was unmistakably the church of the impoverished people whose wretched little weather-beaten slabshacks we had seen in the valley below.

To the right of the church and about twenty feet in front of it there stood a pyramidal monument about ten feet high, made of fieldstones and set upon a broad concrete base. No trained stonesetter or mason had any part in the building of this monument. The base had settled at one end so that the pyramid canted somewhat backward. The stones were unevenly set with ugly gobs of cement extruding between them. The name "Clark" set in smaller stones across the concrete base projected jaggedly and unsymmetrically. The whole structure was very plainly the labor of unaccustomed hands, so definitely a labor of devotion by untrained men that we New England tourists felt a catch in our throats as we gazed upon it. On a broad concrete slab set in the face of the monument were carved these words, "To Our Beloved Doctor."

We sat there in our car, in the shade of the mountain pines, after our simple refreshment, lost in thought and reverie.

High up on the mountain sounded the musical clangor of a cowbell on a bovine invisible in the scrub growth; from a cloudless blue sky the hot sun filtered down upon us through the pines; a phoebe sang from the tip of the pole that surmounted the belfry; that tufted red rascal, the cardinal, peered down from the pine tree and asked, "What-cheer, what-cheer;" a blue jay scolded in the manner of blue jays North and South; down in the valley far below us a bobwhite challenged the world in music.

The worn little church, the hot beautiful day, the birds, the perplexing monument before us—all these combined to give the occasion a significance, an importance difficult to explain. Yet, and there were three of us, we all sensed that something vital to us awaited our search. And so we left the car and walked around the church into the mountain graveyard. Few were the polished markers as we know them in New England. One such marked the resting place of a Sergeant of the Air Force, brought home to lie forever in his mountain soil. Another denoted the grave of a Corporal of the Infantry. A few such others only. The minister who had died in 1926 was honored by a modest stone. Grave after grave after grave was marked by small fieldstones, unlettered, no larger in size than my two hands; the cemetery of a people for whom the simple luxury of a polished stone was unthinkable; the cemetery of the folk we had seen in the valley. But at last we found what we sought—the grave of the man in whose honor had been erected the pillar before the church.

At its head stood the largest polished stone in that yard. On it was chiseled "Dr. Henry Clark, 1859-1928," and below this, "He Loved Our People." We stood there in silence and in reverence, comprehending a little of what this man must have meant to these people. These people, who, too poor to afford lettered stones for their own dead, had each contributed his or her mite that their beloved physician-friend should be remembered.

We thought long thoughts, the two of us who were doctors, and the lady who was wife of one and mother of the other. We thought of a life lived in devotion to a poor mountain people; a life spent first on horseback and later fighting a Model T Ford over the mountain roads; a life consecrated unselfishly to service; a life so lived that twenty-two years after its ending fresh flowers on Memorial Day softened the outline of the grave. We turned finally to leave, but as we passed through the gate we looked back at the headstone shining in the sun, and to us it seemed beautifully appropriate that at that moment there came from the tall dark pines beyond the grave the hauntingly sad, sweet lament of the mourning dove.

There are occasions in the lives of all of us when it is given to us to see and to feel more acutely than is our usual wont. Unexpectedly, suddenly and oft-times under circumstances that in retrospect surprise us, our capacity for perception and feeling bursts its shackled bonds and we see, we really see and feel with an acuity that startles us—a landscape, the sea, the sky, a human being; we marvel and we remember. As long as we live that vivid impression returns to us.

So it was with us then. So it is and so it shall be. We drove away in silence and for long we spoke no word, and yet I knew that to my two companions, as to me, a sermon had been preached. We groped for the words which we then remembered incompletely:

"Now my comates and brothers in exile:
Sweet are the uses of adversity;
Which, like the toad, ugly and venomous,
Wears yet a precious jewel in his head;

And this our life exempt from public haunt
Finds tongues in trees, books in the running brooks,
Sermons in stones and good in everything.
I would not change it."

In my own case that scene always brings back the life of my own father, a country doctor for forty-five years. It brings back the saga of my uncle, a general practitioner in rural Maine for forty years. Two men of each of whom it also could be written: "He Loved Our People." As I think of Dr. Clark and then of these two men whom I knew so well, and who were graced in part at least with Dr. Clark's nobility, the troubles that beset us today fall a little better into perspective. When I remember their lives, I experience a deep humility for my profession.

I wonder if we, many of us, keep firmly enough in our hearts and minds the sense of duty, service and love of fellowman which actuated them. I wonder if some, at least, of our problems of public relations are not traceable to the diminution, on the part of some of us, of that spirit of dedication—consecration, if you will—to the care of the sick first, above and beyond all thought of selfish consideration. Especially do I muse upon this line when in our conclaves of specialists one sees evidences of cupidity emerge in the discussions as to surgical fees for services rendered to the insured in the low financial brackets. How often this eagerness for the last possible dollar shows most glaringly in some of us who drive the biggest cars, and own the richest homes.

I claim no exemption for myself, my friends. Eagerness for the larger fee has not been unknown to me. I throw no stones today, for my house, too, is made of glass.

I throw no stones, I do but meditate and wonder. I wonder if in this age of specialization we may not have as a group, we specialists, in some degree lost the clear vision of the Holy Grail of unselfish medical service which led our forefathers (and still leads many of our general practitioners), which led these forefathers through snow and ice and over rutted roads into the valleys and over the mountains, and which they bequeathed to us for safe keeping.

The shadow of a doubt that we may be indifferent custodians of this glorious heritage is abroad in the land. I do not subscribe in whole to this doubt of course. It is my only boast that I am a member of the greatest profession on earth. The greatest satisfaction of my life is that one of my sons chose to be a doctor. And yet this cloud of doubt hovers over us. In truth, we admit this by the very measures we take to dispel it—County-Society Grievance Committees, purges of the fee-splitters from our hospital staffs, acceptance by most of us of insurance schedules set up, in part at least, to protect the low-income group from gouging. These and other reactions which we need not enumerate attest our recognition of that shadow. Reactions like these are good. They point up the truth that the great majority of the profession are fair and understanding men and women, that in their hearts is compassion and love of fellowman.

Let us by all means set up all the safeguards that time and trial prove of benefit to the public and thus, indirectly, to us. But, better than that, let us all, while we move forward in technical and scientific triumph, let us all remember to look back to the men whose dedication of their lives—a dedication often akin to the abnegation of self which characterizes certain religious orders—whose dedication, in storm and fair weather, in hamlet, town and city, under difficult circumstances, whose dedication, I say, gave us that great gift, that superlative gift which we accepted lightly when we entered upon our practice: the gift of unlimited public confidence and trust, yes, even love.

These men entered upon the practice of medicine inspired with a sense of duty, service and love of fellowman. They hoped to earn a living, of course, to be able to educate their children and to have a decent home; yes, even to lay by a fund for an independent old age. But they were not primarily actuated by a desire for wealth, nor did they regard the patient as a lamb to be fleeced.

Today, there are among us a few, but still too many, who do so regard the patient. Skilled in medical procedures, buttressed by the antibiotics and blood banks, so that miracles are wrought daily by their brains and hands (miracles in the eyes of the lay public, and even miracles to us), they forget the ideals which should guide them. They exact their pound of flesh.

I wonder if at least a part of this attitude is not due to the impersonality of specialism, to the fact that, working entirely in office and hospital as we do, the former intimate protective relationship of doctor to patient has been largely lost. I question if to some of us the patient is no longer a patient but just a "case." Is that one reason why, for instance, the cruel evidences of cupidity emerge at times in

our discussions of voluntary medical insurance plan fees and the scornful indifference to public sentiment? How otherwise can be explained the arrogant flouting of general opinion, unless, and this I find hard to accept, unless, indeed, they are evil men who take this stand.

I prefer to believe that they are men of coarse and insensitive nature, men who never should have been admitted to schools of medicine however able they may be—not evil men but unthinking and socially unoriented men whose ideals have been tarnished by too sudden exposure to the allurements of great wealth, of second generation social prestige, of greasy recognition of equality by their newly rich friends. Arrogance, Avarice, Abuse of Privilege—these are their sins.

Let them pause and remember. The public inevitably finds means to deal with a social group which blatantly exhibits these faults. A great financier once said, "The public be damned," and the public destroyed the power of his group. A queen once said, "Let them eat cake," and she was beheaded! An early politician said, "The people, Sir, is a great beast," and the people shunted him aside.

I have no fear that the type of whom I speak will not be taken charge of by the public. "The mills of the Gods grind slowly but they grind exceeding fine." The danger is that in its disgust and abhorrence, the public will put crippling restraints upon the majority who are just and reasonable. That possibility is imminent! Unless by the moral force of the majority, means are found to discipline these Robber-Barons among us, the public will surely, and, I fear excessively, discipline the entire profession. Until means are found, until we can ourselves set limits to the excesses of our stubborn and willful colleagues—and I believe we shall find the means to do so—we all can do one thing of infinite importance. We can, as George Washington said, "raise a standard to which the just can repair."

That standard shall be the example which we must maintain, the example of fairness, of compassion, of love of man. And, it will help us to maintain that standard if we remember the men who carried that banner before we came upon the scene; not only Dr. Clark, but the kind, self-sacrificing men who were doctors to your families before the era of the specialist, before the era of wealthy doctors, before the era of public doubt and mistrust and suspicion and smouldering resentment.

Let us remember them. Let us be guided by their conduct, and in so doing, shall we not only better serve the public but perchance, by the contrast thus afforded, sufficient pressure will be exerted to correct unspectacularly, but effectively, the evil of which we speak. And who knows? Perhaps for each of us there may be a few, at least, who shall say as it was said of Dr. Clark:

"He Loved Our People."

27th CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

New Haven Hospital and the Yale School of Medicine, New Haven
September 17, 18, 1952

The 1952 Clinical Congress will be concentrated in two days instead of the customary three days and all the meetings will be held at the New Haven Hospital and the Yale School of Medicine.

Three sessions will be held simultaneously in three different meeting places giving a broad selection of topics. Material in the field of general medicine and related subjects will be presented on Wednesday, September 17, and surgery and related subjects will be presented on Thursday, September 18.

Registration for members of the Society will be $3 and non-members $4. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be served on both days by the New Haven Hospital.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMIS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Hospital-Physician Relationship

One need only read the annual report of the Committee on Hospital and Professional Relations of the Medical Society of the State of New York for 1951-1952[1] to realize that all is not as it should be in the relationships existing between certain segments of the medical profession and the hospitals. As John P. Bowler, M.D., of the Hitchcock Clinic, Hanover, N. H. recently stated before the Council of the New England State Medical Societies, the basis of all the problems existing in hospital-physician relationship is economical. We as physicians should stop whistling in the dark and being hypocritical and realize that the whole problem is one of the cost of good medical care.

In December, 1951 the House of Delegates of the AMA approved a statement from the Board of Trustees entitled "Guides For Conduct of Physicians in Relationships with Institutions," a substitution for the previous "Hess Reports." The important paragraphs in this statement are these:

"A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.[2]

"It must also be remembered that fee splitting with a hospital is just as unethical as fee splitting with another physician."

Several hearings were held in the larger cities of New York State with the result that it was discovered that the majority of pathologists, roentgenologists, anesthesiologists, physiatrists, and electrocardiographers attending the hearings were discouraged and disillusioned because of the conditions under which they worked. The major share of these dissatisfactions stemmed from the contractual relations in existence. The Committee's report baldly states that "with few exceptions, pathologists, roentgenologists, etc., are being exploited by the hospital." The principal feature of this exploitation appears to lie in the fact that x-ray, pathology, and pharmacy departments of a hospital are expected to yield magnificent returns with which the deficits of other departments may be met. Of course it is obvious that many of these specialists have made contracts which have been detrimental to them, but their reply is to the effect that there seemed to be little else they could do if they and their families were to eat.

Mr. Robert Cutler, in an address delivered before the American Hospital Association in 1951 and reprinted in this JOURNAL,[3] goes to great pains to show how the present contracts existing between some hospitals and physicians practising within their walls are neither illegal nor unethical. He draws an analogy between the lawyer employed by a trust company and the physician employed by a hospital. To prove his point he states that the hospital is a corporation and as such does not practise medicine

but that the latter is practised by the individual physician on its payroll. By the same reasoning the trust company does not practise law but enjoys the legal advice of the attorneys in its employ. It might be pertinent to ask, because of the analogy drawn, what would happen if an individual approached an attorney for a trust company and demanded legal assistance in securing a divorce? Surely an anesthesiologist would feel obligated to render professional service to a patient in a hospital if the latter requested an anesthetic. Mr. Cutler's argument for the ethical arrangement of salaried physicians with a hospital misses the point entirely. No physician cognizant of the stand of the AMA House of Delegates sees anything unethical in such an arrangement, provided the physician is not exploited.

There has been much "heat and clamor of the fray," as Mr. Cutler so well states. Most of it is due to misunderstanding. In many hospitals the physicians have shown a gross lack of interest in the financial operations of their particular hospital. In other situations the hospital has disregarded the rights and wishes of its professional staff. Teamwork is the sine qua non and without it a community is in peril because it is forgotten in a hopeless conflict. There must be a common meeting ground for professional staff, administration, and governing board. A wise hospital administrator realizes this and makes every effort to effect it. An understanding staff will seek by every means possible to keep its standards high. If, working together, there is ample opportunity for a discussion of the problems common to hospital administration and professional staff, it is difficult to see how the morale of physicians can become so low as the New York Society's committee reports it to be in many hospitals in that State.

1. N. Y. State Jour. Med., 52.9, 1194-1198.
2. Principles of Medical Ethics of AMA, Chap. iv, Sect. 6.
3. Conn. State Med. Jour., 16.6.

The Limitations of Prognosis

"I was beginning vaguely to perceive, that doctors had the fault, equally with parsons, of being much too positive."

Francis Galton

Some time ago the papers were full of accounts of a woman who was told, presumably by a physician, that she had "a year to live." The poor lady, who seems to have swallowed this prognosis, which was not even sugar-coated, as one engulfs a pill, was having a dreadful time deciding what she was going to do during the three hundred and sixty-five days assigned to her by a doctor evidently lacking either in good sense or experience. Francis Galton, who studied medicine but never became a practitioner, was an acute observer and noted the tendency among doctors to make ex cathedra utterances, even though they were not always justified. The Greeks had some words for it in one of their proverbs, "the best guesser is the best prophet." Hippocrates may have had prognosis in mind, when he warned that "Experience is fallacious and judgment difficult."

One wonders sometimes why some physicians are so positive about the duration of a disease in a patient unless they believe, like the biblical prophets of old, that they are acting under divine guidance. It is true, no doubt, that on many occasions an experienced physician can give an accurate prognosis in a general way, for there are some diseases that are almost invariably fatal, but the doctor who makes a prognosis as to the duration of the disease in an individual is either indulging in bravado, speaking without thinking, or has a totally mistaken idea as to the limitations of prognosis. History is full of instances of patients condemned to death who outlived their physician, and no physician of sense and experience prophesies a strict time limit in his prognosis.

I can recall at least two acutely ill patients who appeared to be moribund, both to the attending physician and the consultant, but recovered and lived for years. In chronic diseases the chance for mistaken prognosis covering duration is greater than in acute ones and many a patient is physically damaged by a too pessimistic opinion. It is perfectly proper to let the family know that the patient's condition is incurable, that the average duration of life is a given period of time and may be longer or shorter in this particular patient, but experienced and sensible physicians do not make the mistake of predicting the exact duration of an individual case even though death is obviously inevitable.

G. B.

The Problem in Mental Diseases

A number one problem in our State is inpatient care of the mentally ill, and it is everybody's business. The responsibility of the medical profession is a particular one, for it is from the doctors of Connecticut that leadership in medical problems is ex-

pected. The increasing incidence of mental illness and the lack of facilities for handling these patients in most of the public mental hospitals is becoming rapidly intensified. In some of these hospitals the normal capacity is exceeded by 20 to 35 per cent. Many factors operate to make the situation worse. The increased life expectancy in itself accounts for the fact that one-third of patients in mental hospitals are over 65 years of age.

A main attack repeatedly emphasized by psychiatrists should be along lines of preventive psychiatry. The medical profession and mental hospitals have heavy responsibilities in this field of attack on mental illness in its early stages with modern methods of treatment.

It has been stated that emotional disorders account for at least 25 per cent of all admissions to general hospitals, emphasizing the real need for psychiatric pavilions attached to such hospitals. Aside from the importance to the patient in receiving such preventive treatment in a general hospital area is the advantage of consultation service to be found in the general hospital staff in close association with a psychiatric staff. A further advantage is to be found in the teaching of physicians and nurses in training of this important aspect of medical care. The recent report of the Society's Committee on Mental Health is a significant statement of the present unhealthy state of affairs within our State. The Committee believes that the State Medical Society should take a position of leadership in sponsoring a program designed to bring an inpatient psychiatric service to every general hospital in Connecticut. Such sponsorship means that all Society members should use influence to bring this about.

County P.R.

The development of expanded and intensified public relations programs by two or our larger county associations presages a like development in other counties. The importance of such effort made at this level toward a better understanding of public and professional relationship cannot be overemphasized for it is within the county area that much is to be gained through the intimate knowledge of environment. Two of our counties are availing themselves of help from public relations experts, a sound procedure and one which insures continued and progressive development. Not only public relationships but problems in other professional relationships often find better solution within the county association framework. Professional and hospital relationships within a county area offer a field for study portending toward better understanding. The problem of the relationship of the newcomer in medical practice to organized medicine, over 700 in our State within five years, offers a challenge to county associations capable of bringing significant results.

It is obvious that the expansion of such activities, as here mentioned, requires adequate financial support which most likely means an increase in county dues, and in the counties referred to, this has taken place. It has been in modest proportion, however.

The increase and expansion of county associations' activities in public relations is a sign of health and strength within the medical society and points again to the importance of the county association as the primary and vital unit of organized medicine.

The Student American Medical Association

A national student medical association is not a new idea among American professional school students. Student dental societies are common in dental schools and the Junior American Bar Association has been participated in by law students for many years. The Canadian Association of Medical Students and Interns has 100 per cent school participation and a membership of 95 per cent of all Canadian medical students. The new Student American Medical Association is off to a fine start. Already there are 8,000 members representing 41 medical schools with a prospect of half as many more new chapters this year.

The most important function that the new Association will serve is the opportunity for medical students to present their problems in a nation-wide forum, where they will be heard. The stated policy of the new Journal of the Student American Medical Association is that it belongs entirely to its readers and will be guided principally upon what the student of medicine wants. Not only will he find within its pages scientific papers but also papers dealing with the practical and business side of medicine. It is through the Association and its journal that the American medical student will find the best opportunity for learning about medical practice. When the doctor of tomorrow begins to realize in wider scope some of the socio-economic problems which concern his future and learns further of the cooperative efforts which organized medicine is making to

maintain high standards in American medicine, he will realize more fully his own responsibilities as a student in medicine.

Bertner Foundation Award 1952 (Posthumous) to George Milton Smith

The Bertner Foundation Award for 1952, sponsored by the University of Texas and the M. D. Anderson Hospital for Cancer Research, was awarded posthumously to Dr. George Milton Smith at the Sixth Annual Symposium on Fundamental Cancer Research held at Houston, Texas, April 25 and 26, 1952. The award is conferred on the physician or scientist selected for having made an outstanding contribution in the field of cancer research. The citation accompanying the award reads:

"One of the greatest contributions of any single individual in the wide and intensive effort toward solution of the fundamental problems of neoplastic growth was made by Dr. George Milton Smith. Living his conviction that the problem of cancer should be attacked on the broadest possible front, he stimulated and guided research activity to bring forth its finest fruit.

"He was concerned with the problems of cancer early in his professional career. Upon his suggestion, the Gastric Symposia and Conferences on Normal and Atypical Cell Growth were inaugurated. Informed of the detail, acquainted with investigators throughout the world, as medical director of the Anna Fuller Fund, advisor to the International Cancer Research Fund and the Jane Coffin Childs Memorial Fund, and as director of the National Advisory Cancer Council, the scope of responsibilities he bore was truly immense. Indeed, by whatever criterion of judgment, Dr. George Milton Smith remains unrivaled as an organizer and coordinator of all investigators and their efforts in this important field of scientific endeavor."

Where We Live

According to the census of 1950 three-fifths of our population lives in places with fewer than 25,000 inhabitants. In 1900 almost three-quarters of the population of the United States lived in places under 25,000. The population has doubled since that time and the number of people living in cities has relatively increased, but still by 1950 there were only seven States in which more than half the people lived in cities larger than 25,000. Among these seven are Massachusetts, Rhode Island, Connecticut, New York, and New Jersey. The figures for Connecticut show: living in cities over 100,000—30.1 per cent; 25,000 to 100,000—25.2 per cent; 2,500 to 25,000—8.8 per cent; under 2,500—35.9 per cent. The preference for living in a countryside environment is shown by the rapid expansion of suburban areas. The highest rates of growth are found around the larger cities where the advantages of both town and city may be enjoyed. At heart we seem to be small-town folk. Let us hope so!

U. S. Physicians Pass 211,000 Mark

The number of physicians in the continental United States at the end of 1951 stood at an all-time high, 211,680, according to the annual licensure report of the American Medical Association. This represented a net increase of 2,640 doctors in the United States during 1951.

Official figures indicated that in 1951 there were 6,282 persons who, for the first time, obtained licenses to practice in the United States. The net gain of 2,640 for the year was after an estimate of the number of deaths of physicians based on reports to the AMA.

Alice-Esther Garvin

Miss Garvin was a colorful figure and as editor and secretary she infused much color into Connecticut pharmacy. She all but wrote the *Connecticut Pharmacist* and her column "From the Desk of AEG" was nationally famous as a breezy chit-chat about persons, places and things in pharmacy.

She enthused about the accomplishments of others and was always a source of encouragement.

She fostered the scientific attainments of the pharmacist and devoted herself to maintain his rightful place alongside of the physician in the interest of public welfare. To that end she gave her most loyal support to the JCC, a joint committee with the State Medical Society for maintaining good professional relations. Due much to her efforts this Committee has gained national attention and serves as a model for friendly relations between physicians and pharmacists everywhere.

PROGRESS IN CLINICAL MEDICINE

A NOTE ON THE MANAGEMENT OF CONGESTIVE FAILURE

IRWIN S. ESKWITH, M.D., *Bridgeport*

The Author. *Associate Attending Physician, St. Vincent's Hospital, Bridgeport, Connecticut*

At present, there are three methods that may be used singly or in combination to control edema in congestive failure. These are the use of mercurial diuretics, dietary sodium restriction and the use of cation exchange resins. The last two methods supposedly relieve edema indirectly by assuming that edema fluid will not accumulate if there is no excess salt in the body. The first method acts by removal from the body, by means of renal tubular inhibition, large amounts of water and sodium chloride. Several authors,[1,2,3] including this one, have pointed out the dangers associated with the use of prolonged restriction of sodium from the diet. Recently an editorial in the *American Journal of Medicine*[4] warned of similar hazards. Lippman[5] warned of certain dangers inherent in the use of cation exchange resins particularly in the patient with renal disease. It is this author's opinion that the three methods should not be used in combination since this increases the likelihood of serious hyponatremia. The following case illustrates vividly the dangers that may arise if an overenthusiastic "desalting" regime is carried out.

CASE 1

This patient is a sixty-four year old male seen in my office on May 4, 1950. His chief complaint was dyspnea on exertion. In 1948 he suffered an acute myocardial infarction which was complicated by pulmonary embolism. After being hospitalized for six weeks, he felt well until November, 1949, when he developed for the first time an episode of nocturnal dyspnea accompanied shortly thereafter by edema of the legs and ankles. Since then these symptoms have continued, accompanied by cough and extreme apprehension. He had received irregular injections of mercurial diuretics. For weeks previous to his visit he had been sleeping practically upright. Examination revealed an elderly male dyspneic at rest. Blood pressure was 130/80; pulse, 100; respirations, 30. There were moist rales at both lung bases. The heart was enlarged to the left with the apex in the fifth interspace at the midaxillary line. On auscultation, there was a well defined mid-diastolic gallup. The liver was palpable 8 cms. below the sternal margin. There was slight edema of the legs. The patient was digitalized on whole leaf digitalis. Shortly after the gallup disappeared. He also received, at weekly intervals, 2 cc. of mercuhydrin intramuscularly and he continued, against advice, to restrict his sodium intake. His progress was uneventful until September 11, 1950 when after receiving 2 cc. of the diuretic he commenced, six hours later, to have burning upon urination and passed frequent small amounts of urine. Accompanying this was a sensation of nausea. The next day his legs were swollen much more than they had been. I was called to his home to see him and felt that he was suffering from hyponatremia. He was told to eat some soup containing large amounts of salt and a sandwich of smoked salmon. The next day he felt better; his dysuria had ceased and his ankles were practically edema free. The patient was told to discontinue salt restriction. In October, 1950 he was hospitalized for an attack of primary atypical pneumonia. He recovered from this uneventfully. In May, 1951 a consultant who had seen the patient previously suggested the use of cation exchange resins. Accordingly the patient was placed on 5 Gm. three times daily of "natronil." Although this lengthened the time interval between injections of mercurial diuretics, it did not maintain him free of dyspnea and edema and once every two weeks it was necessary to give him an injection of mercuhydrin.

About four hours after an injection of 2 cc. of mercuhydrin on June 18, 1951, he became nauseated, weak and started to vomit. By 2 A. M. on June 19, 1951 the vomiting had become quite severe and I was called to his home. At this time I was told he was still restricting his salt intake. Thus, for a period of four weeks or more, he had been subjected to sodium restriction and sodium removal by resins and diuretics. When I first arrived at the patient's home, his pulse was 100, he was quite nauseated and complained of abdominal cramps. Within ten minutes after my arrival, he vomited once more and immediately thereafter the pulse reached 160. He became unconscious for one minute and upon regaining consciousness, he became acutely dyspneic. He was then admitted to St. Vincent's Hospital, Bridgeport, Connecticut where his blood pressure was found to be 70/30 and an electrocardiogram showed bizarre, widened (0.14 second) ventricular complexes at the rate of 190 which was diagnosed as paroxysmal ventricular tachycardia. The patient was immediately placed in an oxygen tent and given 0.65 Gm. of quinidine hydrochloride intramuscularly plus sedation. In a little over an hour his pulse fell to 100 with occasional extra systoles. From the time of admission to the evening of June 19, 1951, approximately fourteen hours, 150 cc.

of urine was obtained by catheter. Electrolyte determinations showed serum sodium to be 143 m.eq. per liter; chloride, 101 m.eq. and potassium, 5.1 m.eq. That evening he received a 500 cc. blood transfusion. During the first twenty-four hours in the hospital he voided 165 cc. of urine. The next morning, because of the persistant oliguria, he received 500 cc. of glucose in saline and 500 cc. of 5 per cent dextrose in distilled water by clysis. His blood pressure remained at 70/30. On the evening of June 20 he was given a liberal helping of salted broth. During that night his pulse became somewhat irregular and he became rather drowsy. The next morning, June 21, his blood pressure remained at 72/50 but he produced 570 cc. of urine that day. At this time serum sodium had fallen to 129 m.eq. per liter; potassium to 4.1 m.eq. and chloride to 86 m.eq. The blood urea nitrogen from 28 mgms. on admission arose to 54 mgms. per cent. The total urine sample of June 21 contained 295 mgms. of sodium chloride per 100 cc. which is below the normal value. By June 22 his urine output had reached 980 cc.; blood pressure had risen to 90/60 and his general condition was much improved. On June 23, 1400 cc. of urine was obtained which contained 3/12 Gm. of sodium chloride. The normal amount of chloride in urine of this volume is 10 to 15 Gm. The patient was discharged on June 23 and since that time has been maintained on 2 cc. of mercuhydrin intramuscularly per week. This has relieved the dyspnea and orthopnea quite well but slight traces of ankle edema remain.

COMMENT

This patient had had one warning of difficulty in conserving necessary sodium chloride when he developed his mild attack of edema and oliguria in 1950. When in 1951 he used not only mercurial diuretics and dietary sodium restriction but took cation exchange resins as well, he developed not only serious difficulty but an episode that could have ended in death. It may be argued that the oliguria was secondary to the paroxysmal ventricular tachycardia and the resulting hypotension. However, diuresis actually began when his blood pressure was at the same level as it had been during the episode of arrhythmia. I feel that the repeated vomiting was the precipitating cause of the arrhythmia and that the vomiting in turn was caused by the hyponatremia. Although the admission electrolyte studies were quite normal, this may have been due to an attempt to maintain serum concentrations at the expense of interstitial fluid electrolyte. In twenty-four hours, after parenteral fluid and blood had been given, the sodium chloride fell to subnormal levels. The low percentage of chloride in the urine supports the impression of hyponatremia and hypochloremia.

Schwartz[6] has described so-called hypochloremic alkalosis due to the loss of excessive amounts of chloride following the administration of mercurial diuretics. However, ammonium chloride, especially if coupled with sodium restriction and used with enthusiasm, may cause acidosis.[7]

At times, patients who have been responding to the mercurial diuretics may suddenly cease to respond and continue to accumulate edema even though the drugs have been used in more than adequate dosage. A group of nine such patients were recently described by Iseri, Boyle and Meyers.[8] These patients improved after being subject to a very rigid sodium restriction and cessation of mercurial preparations. The following patient presented such a problem.

CASE II

This patient is a fifty-nine year old male. He was first seen in the office on June 16, 1949. Three years before he had had an episode of severe pain in the chest and right shoulder which was diagnosed as a coronary occlusion and for which the patient was confined to bed for seven weeks. About nine months before coming to my office he developed dyspnea on exertion and swelling of the ankles. He was started on digitalis by a cardiologist. At that time he was told he had high blood pressure. He came to my office because of marked swelling of the legs and feet and an increase in dyspnea which had become worse in the past week. Physical examination revealed a dyspneic male with cyanosis of the lips and fingernails and with what appeared to be moderate atrophy of the shoulder girdle. Blood pressure was 200/110; pulse, 88; respirations, 28. There was narrowing of the retinal arterioles and A-V nicking. The cervical veins were markedly distended. The heart was greatly enlarged to the left with the apex at the sixth interspace at the midaxillary line. There was a grade II systolic murmur present in this area. The rhythm was regular. The lungs contained rales at both bases and there was dullness and diminished breath sounds at the right base. The liver was felt 6 cms. below the right costal margin and was tender. There was marked edema of the lower extremities. Fluoroscopy revealed obliteration of the right costophrenic angle due to pleural thickening. The electrocardiogram showed left bundle branch block. Urine findings revealed a specific gravity of 1024; 2+ albumin; 2+ sugar; occasional hyaline and granular casts. The patient was started on two injections of a mercurial diuretic per week. Following this, four events occurred. First, he lost all evidence of edema. Secondly, he actually gained weight and the atrophy of the shoulder girdle disappeared. Thirdly, his blood pressure began to fall and finally stabilized at 158/80. Fourthly, the 2+ albuminuria and the slight amount of glycosuria present on admission disappeared. These changes occurred gradually over a nine month period. The patient's weight became constant at 183 lbs. and remained so until January, 1951. At that time, although he seemed to get a good response to each injection of mercuthanzin,

he started to reaccumulate edema and cough and dyspnea reappeared. The mercurial injections were increased to three weekly without any weight reduction. In February, 1951 a serum sodium was obtained which showed 159 m.eq. per liter; chloride, 94.8 m.eq. and the serum potassium, 6.5 m.eq. Because of the hypernatremia the patient was started on a rigidly restricted (0.5 Gm. daily) sodium regime and given ammonium chloride tablets. This resulted in dramatic relief in the edema and the weight fell from 191 to 179 in a period of three weeks. During this time he received one mercurial injection. He was maintained on this diet with only occasional mercurial injections until April when edema once more began to accumulate in spite of the low sodium regime and the ammonium chloride. Since April he has received one injection of mercuthanzin weekly and no ammonium chloride. His weight is steady at 184 lbs. The patient consumes sodium chloride as desired.

DISCUSSION

Dock[9] has stated that sodium restriction has little value in the management of the acute phases of congestive failure. Its value lies in the prevention of the syndrome. With the arrival on the scene of cation exchange resins, it is doubtful whether dietary sodium restriction will continue as a common practice. It is unpalatable to the patient. It hampers, to a considerable extent, their social activity. It can lead to serious complications.

It is likewise questionable whether any patient should be indefinitely continued on a program that embraces more than one of the available anti-edema methods as given in the early part of this article. Such combinations, if faithfully followed, may lead to disaster. In my opinion the sole reason that more accidents have not been described is because most patients will not stay on these very rigid diets.

It is suggested that patients with chronic congestive heart failure commence their treatment with digitalization and injections of mercurials given frequently enough to prevent edema. Should this regime become ineffective at any time, ammonium chloride in doses of four to six Gm. daily should be added to the treatment. Should this likewise fail to produce results, then cation exchange resins may be added. However, patients who are difficult treatment problems should have frequent serum electrolyte determinations performed and also urinary studies.

It seems to me that this program affords the greatest safety and the least discomfort to the edematous cardiac patient.

BIBLIOGRAPHY

1. Eskwith, I. S.: N. Y. State Jour. of Med. Vol. 51:10, May 15, 1951.
2. Schroeder, F. R.: Am. Heart Jour. 141, Aug., 1941.
3. McGuire, W. B.: ibid, 137:1377, 1948.
4. Editorial, Am. Jour. of Med., Vol. 11:2, 133, Aug., 1951.
5. Lippman, R. W.: J.A.M.A. Correspondence, Vol. 146: 395, 1951.
6. Schwartz, W. B.: Bull. New Eng. Med. Center, 12:213-218, 1950.
7. Berner, G., Hutchinson, J. S., Dochler, J., Czebrinski, E.: Arch. Int. Med., 88:387-88, Sept., 1951.
8. Iseri, L. T., Boyle, A. J., Meyers, G. B.: Amer. Heart Jour., 40:706, 1950.
9. Dock, Wm.: Advances in Int. Med., Vol. 4:275, 1950, Chicago Yearbook Publishers.

Connecticut Trauma Committee Meets

On May 15 the Connecticut Regional Committee on Trauma, Sub-committee on Education of the American College of Surgeons, met at the University Club in Hartford. Charles W. Goff, chairman, reported that representatives from 23 hospitals were present.

At this organizational meeting a code for Connecticut in the treatment of the hospital emergency care of injured persons was outlined. This group plans additional meetings in the future.

It is hoped that this code will be helpful to hospitals in evaluating their individual practices in the accident rooms.

THE DOCTOR'S OFFICE

Donald G. Arnault, M.D. announces the opening of an office for the practice of surgery at 96 South Main Street, Middletown.

Andrew P. Owens, M.D. announces the opening of an office for the practice of surgery at 144 Golden Hill Street, Bridgeport.

Harold Schwartz, M.D. announces the opening of an office for the practice of radiology at 99 Pratt Street, Hartford.

H. Peter Schwarz, M.D. announces the opening of an office for the practice of internal medicine at 25 Main Street, Norwich.

THE PRESIDENT'S PAGE

At this time the general practitioner is the subject of numerous medical writings as well as being a live topic of conversation among hospital groups. It is the wish of many doctors engaged in general practice that they be given greater opportunities on the working staff of the hospital. This is a worthy desire. There is a need and a welcome for general practitioners in the hospitals of Connecticut.

Medical educators are seeing some of these problems in a new light. It is recognized that a residency training is the training of a specialist and that the intern year should be given over to the training of a doctor for general practice. A slow but certain revision of intern training is being carried out in a number of general hospitals to the end that the one year rotating internship be devoted to a training that will prepare the intern to meet the problems of a general practice.

The general practitioner as a member of the hospital staff, acting as clinician, teacher or student, can be integrated into this intern training program to the mutual benefit of all. As a result of increased responsibilities and greater opportunities on the hospital staff, the general practitioner will acquire and develop new skills and technics. It is hoped that as a result of this association he will retain under his care many of his patients who now seek the advice and treatment of the specialist for ills that can and should be cared for by the general practitioner. It is predicted that under a well rounded out program of intern training for general practice more doctors will be attracted to this important and interesting branch of medicine.

Sir St. Clair Thomson once quoted this sage observation from an obscure French writer: "Specialization in Medicine is the lowest form of this art, when it is not made fruitful by general knowledge. On the other hand, specialization becomes perfection in Medical Art when one practices it as a crowning of this science, after the attainment of general knowledge. One must finish instead of beginning by specialization."

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: 8-0587, 5-0836

Annual Meeting of the Council

The annual meeting of the Council was held on May 8 in the offices of the Society and was called to order at 4:00 P. M. by Dr. Whalen. Dr. Murdock nominated Dr. Howard to continue as Chairman of the Council for the year 1952-1953 and he was unanimously elected. After leaving the chair, Dr. Whalen made brief remarks welcoming newcomers to the Council and then all present were introduced by the secretary. There were present: Drs. Archambault, Buckley, Couch, Danaher, Fincke, Gallivan, Gens, Gettings, Gildersleeve, Howard, Labensky, Shepard, Murdock, Phillips, Root, Russell, Tracy, Walker, Weld, Whalen, Barker. Absent: Drs. Flaherty, Thoms, Ursone.

EXECUTIVE COMMITTEE

The Executive Committee to serve during the summer was appointed as follows: the President, the President-Elect, the Chairman of the Council, Dr. Karl Phillips, Councilor from Windham County, and the Executive Secretary.

SPEAKER AND VICE-SPEAKER

It was voted that the Speaker of the House and the Vice-Speaker should be invited to attend all meetings of the Council as observers.

LINCOLN FOUNDATION

A request from AMVETS Post No. 1, West Haven, that the Society investigate the treatment given by the Lincoln Foundation of Medford, Massachusetts was presented. The secretary's reply to this request had been distributed with the agenda for this meeting. It was voted that the Society would not make the investigation proposed by the West Haven AMVETS Post and that the secretary so inform that organization. It was further voted that the secretary should inform the secretary of the New Haven County Medical Association of those members of that Association who are believed to be using the Lincoln Treatment with the suggestion that their conduct in this connection be reviewed by the Board of Censors of that Association.

GROUP HEALTH AND ACCIDENT INSURANCE

A request from the Board of Trustees of the Fairfield County Medical Association that the Society investigate the "whole subject of health and accident insurance" was presented. Correspondence with the secretary of the Fairfield County Medical Association had already been entered into by the secretary and that correspondence had been distributed with the agenda for this meeting. It was voted that the Society not carry out the study suggested by the Fairfield County Medical Association, since there actually was no necessity for such a study.

COMMITTEE ON THIRD PARTY PAYMENTS

The appointment of a Committee on Third Party Payments, as provided in an amendment to the By-Laws approved by the House of Delegates on April 29 was discussed. It was agreed that each member of the Council submit names of members of the Society to be considered for appointment to this committee and that selection from the names so submitted would be made by the Executive Committee as promptly as possible. The committee so appointed will serve until the annual meeting of 1953, when nominations will be presented by the Nominating Committee as provided in the By-Laws.

STATE RESPIRATOR CENTER

A resolution from the Fairfield County Medical Association concerning the establishment of a state center for the care of poliomyelitis was presented. It was voted that the secretary of the Society confer with Dr. Hart Van Riper, medical director of the National Poliomyelitis Foundation concerning this proposal and report to the Council.

STATE DEPARTMENT OF MENTAL HEALTH

A recommendation contained in the annual report

of the Society's Committee on Mental Health that the "President of the State Society or the Council appoint a small committee to carry on such a program of education and publicity regarding the creation of a State Department of Mental Health" was considered. It was voted that the Committee on Mental Health be asked to carry out this purpose and the committee confer with Mr. Burch and the press and publicity personnel in the office of the Governor.

INPATIENT PSYCHIATRIC SERVICES

A recommendation contained in the annual report of the Committee on Mental Health "that the State Medical Society should take a position of leadership in sponsoring a program designed to present an inpatient psychiatric service to every general hospital in Connecticut" was considered and it was voted that this project be referred to the Society's Committee on Hospitals.

EXPERT MEDICAL TESTIMONY

A recommendation contained in the annual report of the Committee on Expert Medical Testimony, "that steps be taken for it to be joined to a similar committee of the Connecticut State Bar Association, if one were to be formed, in order to continue its studies and eventually make concrete recommendations which may result in the adoption of some practical procedure for the improvement of expert medical testimony," was presented. It was voted that the chairman of the Committee on Expert Medical Testimony be authorized to confer with officers of the State Bar Association and take other steps necessary to have a joint committee of the two organizations formed.

Meetings Held During June

June 4—Governor's Special Committee on State Hospitals
June 6—Advisory Committee to the State Board of Examiners for Nursing
June 10—Dental Conference Committee
June 11—Committee on Hospitals
June 12—Committee on Public Health
June 17—Connecticut Medical Examining Board
June 25—Committee to study Maternal Mortality and Morbidity
June 26—Council Meeting

STUDENT MEMBERS

The following student members were elected:

Frederick A. Klipstein, Greenwich
Columbia University, College of Physicians & Surgeons—Class of 1954
Pre-Med: Williams College
Parent: August Klipstein

Edward A. Krull, Oakville
Yale School of Medicine—Class of 1955
Pre-Med: Yale
Parent: Alexander Krull

Raymond L. Standard, Hartford
Howard University—Class of 1952
Pre-Med: Howard
Parent: Vivian L. Standard

John S. Wilson, West Hartford
Columbia University, College of Physicians & Surgeons—Class of 1955
Pre-Med: Trinity College
Parent: Dr. William A. Wilson

1952 ANNUAL MEETING

The secretary presented a brief report on the annual meeting which was held in Hartford April 29, 30 and May 1. He reported that the registration was approximately 1,200, which was the largest recorded at any meeting.

Dr. Lyman Honored By 3,800

Gaylord Farm Sanatorium had a gala day Saturday, May 24, when it celebrated the 50th anniversary of its founding, honored its one and only medical superintendent during those 50 years, and dedicated the new Florence R. Burgess Infirmary. It was a great day for David R. Lyman and well he deserved it. As has been stated before in these columns, "Gaylord Farm Sanatorium is Dave Lyman and Dave Lyman is Gaylord Farm Sanatorium."

At least 3,800 alumni of the Sanatorium and friends of Dr. Lyman gathered to partake of a barbecue chicken dinner served out of doors from four huge charcoal pits. Following the presentation of a play written by former patient John Cecil Holm on the life of Dr. Lyman and the history of the Sanatorium and presented by the Yale Drama Department, James McKenna, president of the Gaylord Farm Association, took over as master of ceremonies. The David

Russell Lyman Medal was awarded to Dr. William H. Morriss, medical director of Gaylord Farm, by Dr. Thomas P. Murdock of Meriden, substituting for the ill Senator Brien McMahon.

Following a vote of the House of Delegates of the Connecticut State Medical Society on April 29, Dr. Lyman was awarded an honorary membership in the Society, becoming the only living man to possess that honor. Dave Lyman was obviously deeply touched by this presentation, made by Thacher W. Worthen, vice-president of the State Medical Society. Dr. Worthen pointed out to the assembled gathering the position of leadership held by Dr. Lyman and the innumerable honors bestowed upon him. He also recalled the vision and foresight of the New Haven County Medical Association in appointing a committee in 1902 headed by Dr. Oliver T. Osborne whose function was to study the problems of tuberculosis. This study culminated in the selection of Dr. Lyman as medical superintendent of the new sanatorium. Discarding his prepared speech in responding to the presentation he said, "This means more to me as a tribute I can pass on to her than I can tell you."

Governor Lodge and Mrs. Lodge were on hand to grace the ceremonies. The Governor was shown about the grounds and informed that the Association raised all of the cost of the new infirmary—about $330,000. In fact, it was brought out that the State has contributed only about $25,000 for capital expenditures at Gaylord since the institution was founded. The ceremonies were fittingly brought to a close by the benediction pronounced by that patriarch and scholar, Rev. Anson Phelps Stokes, an original incorporator of the Gaylord Farm Association.

New Academy of Obstetrics and Gynecology Elects Officers

The new president of the American Academy of Obstetrics and Gynecology is Carl P. Huber of Indianapolis and Robert A. Kimbrough, Jr., of Philadelphia is the new president-elect. Ralph A. Reis of Chicago, in addition to being reelected as secretary, was chosen to be editor of the Academy's new journal which will be published monthly beginning in January, 1953.

Next annual meeting of the Academy will be held at the Palmer House, Chicago, December 15-17, 1952.



Dr. Wallace Takes Over Blood Program

Victor G. H. Wallace has resigned as medical director of the State Welfare Department to accept the position as medical director of the Connecticut Regional Blood Program. Dr. Wallace is a Fellow of both the Royal College of Surgeons and the American College of Surgeons and following service in both World Wars practiced obstetrics and gynecology in Norwalk, Connecticut. In 1949 he came to Hartford to assume his duties at the office of the Commissioner of Welfare.

In his new position Dr. Wallace will supervise the entire blood procurement program of the State with headquarters in the former Wilson laboratory building on Retreat Avenue. His position in the Welfare Department has been assumed by Harold Pierce, formerly with the State Department of Health.

Pensions for Physicians

(From the Bureau of Medical Economic Research, AMA)

Recently physicians have been renewing their interest in several pension proposals. Self-employed physicians are now among those groups not under the Social Security Act. An argument frequently used to attempt to persuade older professional per-

sons to urge extension of the act is a so-called bargain feature; for example, to take an extreme case, it is pointed out that a person approaching the age of 65 can pay a minimum of $121.50 during the last 18 months and receive a social security pension of $80 per month for himself at age 65 plus a monthly pension of $40 for his wife at age 65; moreover, the wife's pension would be increased to $60 per month if she outlived her husband. Actuaries estimate that the single premium at age 65 for an insurance company annuity paying these benefits would be about $23,000. Monthly pensions of $120 received once or twice would exceed the minimum cost. The attractiveness of this lure is greatly lessened when a professional man approaching age 65 asks himself: "Who is going to pay for my pension under the Social Security Act if I do not pay for it?" The obvious answer is that the balance of the cost must be paid by the working population, by the profession's younger colleagues, by their neighbors, by their children, and perhaps by their children's children. This is a moral question for all those approaching age 65 who are considering the desirability of coming under the Social Security Act. They must decide whether they want to pay their own way for their own pensions or want younger persons to bear the burden. Moreover, the actions of the House of Delegates of the American Medical Association have indicated other objections to bringing physicians under the Social Security Act, notably, that the pension does not start at age 65 unless the eligible person ceases to earn more than $50 per month and that the extension of Social Security increases the threat of compulsory health insurance.

Physicians should be interested in the Reed-Keogh bill (HR4371 and HR4373), which would amend the Federal Internal Revenue Code so as to enable self-employed professional persons to exclude from current taxable income amounts sufficient to finance a reasonable retirement annuity. In other words, this bill would provide for the self-employed the counterpart of the pension that the company physician, lawyer, dentist, accountant, engineer, architect, and chemist can expect from his employer. It would be a voluntary pension plan. The purpose of the bill is to remove the discrimination in federal income tax laws initially created in 1942 against the self-employed in the matter of pensions. A self-employed person would, of course, have to declare the annuity as it is received during his retired years as taxable income; that is, the bill provides for tax deferment until the retired years of life of certain portions of income received during the working years of life. The bill does not permit tax avoidance as such.

For several years the Director of the Bureau of Medical Economic Research and the Director of the Bureau of Legal Medicine of the American Medical Association have been cooperating with representatives of more than a score of professional organizations in the study of tax deferments for professional persons. On January 11, 1952, these representatives created a Coordinating Committee on Retirement Benefits for the Professions and the Self-Employed, at the suggestion of the Special Committee on Retirement Benefits for Lawyers of the American Bar Association. The chairman of both committees is Mr. George F. Roberts, a lawyer of New York City. A smaller steering committee of only five members of the coordinating committee has been established. One member, in addition to Mr. Roberts, represents the American Bar Association, and the other three represent the American Medical Association, the American Institute of Accountants, and the American Farm Bureau Federation. The steering committee met in New York City on March 21 and in Washington on March 25 to consider amendments to the Reed-Keogh bill that would prevent any person from obtaining more than a moderate pension under its tax deferment provisions. The House Ways and Means Committee has decided to hold hearings on this bill, at which time certain amendments will be proposed by the steering committee. It may be that the limits in the bill on the amount of annual income excludable from income taxes, that is, $7,500 or 10 per cent of earned income—whichever is the lesser amount—will be modified. Every self-employed professional man should urge his Congressman to follow closely this bill and urge other self-employed persons, such as farmers, other sole proprietors, and partners to do likewise.

Another notable feature of this bill which was designed primarily for the retirement needs of the self-employed, is that it offers the same opportunity to the employed to defer taxes. The employed person can exclude annually from current taxable income 10 per cent of his earned income—but not more than $7,500—minus any amounts contributed during such taxable year by his employer to a pension plan approved by the Treasury Department. By extending equal opportunity to the employed the lawyers who drafted this bill hope to assure its con-

stitutionality even though it appears unlikely that many employed persons would seek the tax deferment benefits provided.

Each year several billion dollars are paid by employers irrevocably into pension trusts and insurance annuity contracts for the benefit of their employees. Neither the employer nor the employee who is benefited pays any current income tax on this vast sum of money, although the employee will declare the employer's share of his pension taxable income when he receives it years later. Simple justice requires that a similar opportunity for tax deferment be given the self employed, especially professional men, whose peak earnings, bunched into a comparatively few years, are hit hard by steeply progressive income tax rates and who are forbidden by law to practice their professions as corporations. Either the counterpart of these industrial pension systems should be made available to the self employed or the provisions of the 1942 Revenue Act providing income tax deferment for the employee for his employer's annual contribution to approved pension plans should be repealed!

Income Tax Deduction For Postgraduate Work

During the past several years the House of Delegates has passed resolutions dealing with deductibility, for federal income tax purposes, of the expenses incurred by physicians for postgraduate work. The Commissioner of Internal Revenue has been approached on several occasions by the American Medical Association to reconsider and reverse the old opinion disallowing the deductibility of such expenditures but without success. Special counsel was retained in Washington early in 1952 to prosecute this question to a satisfactory conclusion. It was discovered that there was pending before the U. S. Tax Court a case in which a lawyer had been denied the right to deduct certain expenditures made by him in attending a series of lectures given by the New York University Institute on Federal Taxation. This case involves the same issue in which physicians are interested.

A brief has been filed for the American Medical Association as amicus curiae. In this brief attention is called to the fact that Section 23 (a) (1) (A) of the Internal Revenue Code provides for the deduction of "all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business." It is the contention of the AMA's counsel that "the ordinary and necessary expenses" of a trade or business include the annual outlays customarily incurred by a professional in keeping abreast of current developments in his area of competence.

The Supreme Court has held that an outlay is a business expense if it "is directly connected with" or "proximately resulted from" the taxpayer's business. The Supreme Court has also declared that an expense is "ordinary" if it is "normal, usual, or customary," "of common or frequent occurrence in the type of business involved," or "embraced within the normal overhead or operating costs."

The argument points out that physicians as well as other professionals must maintain a continuous process of education in order adequately to serve their clients. Expenses incurred in such a continuous process are not only necessary but unavoidable if taxpayers are to compete successfully in professions which place a substantial premium on new knowledge and new techniques.

A decision was rendered by the Fourth Circuit in 1950 in Hill v. Commissioner which is quite relevant to the present context. There the taxpayer had taught public school for 27 years and obtained the highest certificate issued to teachers by the State board of education. She was notified that her certificate had expired and that a renewal was obtainable only if she acquired certain college credits or passed an examination on five selected books. As a result, she elected the former alternative and attended summer school at Columbia University. Later she sought to deduct the costs incurred as ordinary and necessary business expenses.

The Fourth Circuit agreed that the cost of attending the courses easily qualified as ordinary and necessary expenses of carrying on a trade or business. In reaching its conclusion, the Court stressed the fact that the taxpayer incurred the expenses "to maintain her position; to preserve, not to expand or increase; to carry on, not to commence." Similarly, professional practitioners attend lecture courses in their specialized fields to maintain and preserve their positions. Obviously, a practicing lawyer or doctor does not incur such expenses in order to enter his chosen field. He is already engaged in practice, and is only interested in maintaining his position in the face of recurring changes in his restricted area of competence.

(Continued on page 566)

AMERICAN MEDICAL EDUCATION FOUNDATION

FUND-RAISING COMMITTEE

CONNECTICUT STATE MEDICAL SOCIETY

Physicians who have contributed in the current campaign and those who have indicated they are contributing directly to their medical schools as of June 10

FAIRFIELD COUNTY

Meyer Abrahams, New Canaan
Payson B. Ayres, Cos Cob
Joseph H. Beaudry, Bridgeport
Sidney H. Beck, Bridgeport
Alice I. Bernheim, Greenwich
Maxwell Bogin, Bridgeport
John D. Booth, Danbury
Eugene D. Brochu, Danbury
Claudius V. Calvin, Bridgeport
Philip R. Carroll, Jr., Bridgeport
Edwin R. Connors, Bridgeport
William H. Curley, Jr., Bridgeport
Rector T. Davol, Greenwich
Irving S. Dichter, Stamford
Dean H. Edson, Danbury
Ralph H. Edson, Shelton
J. Benton Egee, Newtown
C. Louis Fincke, Stamford
Joseph Fine, Stamford
Wesley F. Fitzpatrick, Norwalk
John G. Frothingham, New Canaan
Thomas H. Gaetz, Shelton
William A. Geer, Bridgeport
Harold Genvert, Norwalk
Donald F. Gibson, Danbury
Frank M. Goldys, Danbury
Grace V. Gorham, Norwalk
John E. Grigas, Greenwich
Arthur S. Griswold, Bridgeport
Crawford Griswold, Bridgeport
R. Warren Hall, Trumbull
James V. Halloran, Greenwich
Francis M. Harrison, Stamford
George W. Hebard, New Canaan
Robert B. Hiden, New Canaan
Joseph H. Howard, Bridgeport
A. Boswell James, Bridgeport
Leon Kaplan, Bridgeport
Morris E. Katz, Norwalk
Russell A. Keddy, Darien
Walter W. Kemp, Stamford
Marjorie S. Knauth, Wilton
Neil F. Lebhar, Westport
Paul Lengyel, Bridgeport
R. Harold Lockhart, Bridgeport
Jane Lockwood, Greenwich
Edward J. Lynch, Shelton
Frederick W. McFarland, Stamford
John McMahon, South Norwalk
Louis Newton, Bridgeport
Robert A. Northrop, Norwalk
Frank T. Oberg, Bridgeport
Ralph L. Parker, Bridgeport
Frederick A. Patterson, Norwalk
Morris P. Pitock, Bridgeport
John S. Poczabut, Stamford
Katherine S. Quinn, Bridgeport
Cotton Rawls, Stamford
Harold Ribner, Bridgeport
Edward R. Roberts, Bridgeport
Joseph E. Savak, Springdale
Michael V. Sciortino, Bridgeport
Howard P. Serrell, Greenwich
Milton Sheiman, Bridgeport
Samuel C. Sheiman, Bridgeport
Homer B. Shoup, Westport
Alan R. Small, Bridgeport
Nicholas V. Spinelli, Bridgeport
Charles H. Sprague, Bridgeport
Eric E. Stietzel, South Norwalk
Luther M. Strayer, Bridgeport
Oliver L. Stringfield, Stamford
George L. Tunick, Greenwich
Frank Turchik, Bridgeport
Edward J. Wagner, Ridgefield
Ellwood C. Weise, Bridgeport
Dexter Wolfson, Bethel
Francis B. Woodford, Ridgefield
Robert H. Wyatt, Stamford
Isidore Yasser, Bridgeport
John B. Zielinski, Bridgeport

HARTFORD COUNTY

John C. Allen, Hartford
Egbert M. Andrews, Hartford
Preston N. Barton, Terryville
Israel Beatman, Hartford
Alfred J. Berger, New Britain
Edmund Beizer, Hartford
Charles T. Bingham, Rocky Hill
Francis J. Braceland, Hartford
Donald A. Bristoll, New Britain
Francis S. Buccheri, New Britain
Burdette J. Buck, Hartford
Walter L. Butterfield, Hartford
Lewis L. Chester, Hartford
Ettore F. Carniglia, Hartford
Timothy L. Curran, Hartford
Walter A. Dalmain, Bristol
Marvin B. Day, Hartford
Edward G. Deming, Hartford
William J. Doerr, Hartford
Ralph E. Durkee, Hartford
Sidney D. Eisenberg, New Britain
Ralph M. Filson, West Hartford
Amos E. Friend, Manchester
Edward M. Finesilver, Hartford
James C. Fox, Jr., Hartford
John N. Gallivan, East Hartford
Isidore S. Geeter, Hartford
Forrest D. Gibson, Hartford
J. Raymond Glazier, Hartford
Howard W. Gourlie, Thompsonville
Leroy C. Grau, Hartford
Dwight Griswold, Hartford
George M. Gura, Southington
Jack Gurwitz, Hartford
Louis D. Harris, Hartford
Francis W. Helfrick, Manchester
Harold A. Howard, Wethersfield
Glover E. Howe, Hartford
Charles E. Jacobson, Hartford
Derick A. January, Hartford
Joseph F. Jenovese, Hartford
James C. Johnson, Hartford
Frank S. Jones, Hartford
Robert H. Karotkin, Hartford
Robert R. Keeney, Manchester
John J. Kennedy, Jr., Windsor Locks
Isaac W. Kingsbury, Hartford
Joseph Klein, Hartford
Irving H. Krall, Hartford
William J. Lahey, Hartford
R. Starr Lampson, Hartford
J. Whitfield Larrabee, Hartford
John C. Leonard, Hartford
Howard J. Lockward, Manchester
Raymond D. Lublin, East Hartford
George A. F. Lundberg, Manchester
Francis L. Lundborg, West Hartford
William H. MacCready, Windsor
Morris M. Mancoll, Hartford
Edward Martin, New Britain
Stevens J. Martin, Hartford
Nicholas A. Mastronarde, Hartford
Donald J. McCrann, Hartford
Martin P. McCue, Hartford
Sidney R. McPherson, Hartford
James R. Miller, West Hartford
Joseph A. Mlynarski, New Britain
Philip J. Moorad, New Britain
Michael J. Morrissey, Hartford
John O. Nolan, Hartford
Harriett E. Northrup, West Hartford
Stanley H. Osborn, West Hartford
Robert H. Osmond, Hartford
Salvatore S. Piacente, Hartford
Maurice M. Pike, Hartford
William H. Pomeroy, Poquonock
Foster E. Priddy, Wethersfield
John V. Prignano, Manchester
Sidney S. Quarrier, Hartford
John F. Reed, Hartford
Renato A. Ricca, Glastonbury
Frederick P. Rogers, West Hartford
John C. Rowley, West Hartford
Merril B. Rubinow, Manchester
Charles T. Schechtman, New Britain
William B. Scoville, Hartford
Daniel E. Shea, Hartford
Marguerite D. Shepard, Newington
Warren B. Silliman, Windsor
George W. Sorokowski, East Hartford
E. Myles Standish, Hartford
Hilda Standish, Hartford
James H. Standish, Hartford
Theodore W. Steege, Hartford
William F. Storms, Wethersfield
Hartwell G. Thompson, Hartford
Ralph M. Tovell, Hartford
William H. Upson, Suffield
Euen VanKleeck, Hartford
N. William Wawro, Hartford
Sylvia Weiner, Hartford
Stanley B. Weld, Hartford
Gideon R. Wells, Hartford
Benjamin B. Whitcomb, Hartford
Benjamin V. White, Hartford
Otto G. Wiedman, Hartford
William M. Wiepert, Avon
John T. Winters, West Hartford
Harold B. Woodward, Bristol
Thacher W. Worthen, Hartford
Raymond Yesner, Newington
Edmond R. Zaglio, Manchester
Oscar H. Zarkin, Hartford
Norman Zeldis, Hartford

LITCHFIELD COUNTY

George L. Cushman, North Woodbury
Thomas J. Danaher, Torrington
Meredith M. Dickinson, Watertown
William G. H. Dobbs, Torrington
G. Robert Downie, Winsted
Louis E. Garston, Torrington
Harry B. Hanchett, Torrington
Arthur H. Jackson, Washington
William B. Lyons, Thomaston
Andrew W. Orlowski, Torrington
Edwin G. Reade, Watertown
A. Rocke Robertson, Torrington
Daniel P. Samson, Thomaston
Roy V. Sanderson, Winsted
Hope Sherman, Pleasant Valley
James T. Smith, Winsted
Francis A. Sutherland, Torrington
Frank D. Ursone, Norfolk
Floyd A. Weed, Torrington
Edward H. Wray, Jr., Litchfield

MIDDLESEX COUNTY

William F. Bauer, Jr., Middletown
Harriet Bixby, Mansfield Depot
Willard E. Buckley, Middletown
Frank H. Couch, Cromwell
G. Mansfield Craig, Middletown
Clair B. Crampton, Middletown
Harry S. Frank, Middletown
Richard F. Grant, Cromwell
Carl C. Harvey, Middletown
Walter R. James, Essex
John J. Korab, Middletown
Louis O. LaBella, Middletown
Christie E. McLeod, Middletown
Benjamin A. Roccapriore, Middletown
V. Gerard Ryan, Portland
Henry Sherwood, Middletown
Archibald W. Thomson, Middletown
F. Erwin Tracy, Middletown
Sophie C. Trent, Middlefield
Vincent J. Vinci, Middletown
Harry S. Whiting, Middletown
William E. Wrang, Middletown

NEW HAVEN COUNTY

Elisabeth C. Adams, Guilford
Edward P. Allen, New Haven
Creighton Barker, New Haven
Walter E. Barney, Milford
Sidney Berman, Stratford
Courtney C. Bishop, New Haven
Samuel P. W. Black, New Haven
Eugene M. Blake, New Haven
Dana L. Blanchard, Branford
George Blumer, San Marino, Calif.
Joseph J. Bowen, Jr., Waterbury
Eugene B. Brody, New Haven
Norton Canfield, New Haven
William C. Carey, Meriden
Anthony L. Carpentieri, Waterbury
John A. Chasnoff, West Haven
Jules V. Coleman, New Haven
Michael J. Conroy, Meriden
David F. Conway, New Haven
C. James Coppeto, Waterbury
Morris Coshak, Waterbury
Thomas Cottiero, Waterbury
Edward C. Curnen, Jr., New Haven
Hermann S. Cutler, New Haven
Marion Dallas, New Haven
Arthur B. Dayton, New Haven
Clyde L. Deming, New Haven
Theodore S. Evans, New Haven
William Finkelstein, Waterbury
Joseph A. Fiorito, New Haven
William J. H. Fischer, Milford
Morris Freedman, New Haven
Clements C. Fry, New Haven
Russell V. Fuldner, New Haven
Henry A. Geib, Milford
Arthur J. Geiger, New Haven
William J. Goade, Boston, Mass.
Morris Goldstein, New Haven
William M. Good, Waterbury
Frank D. Gray, New Haven
Frieda G. Gray, New Haven
William Grillo, Waterbury
Morris A. Hankin, New Haven
John E. Harty, Waterbury
Albert E. Herrmann, Waterbury
Maurice M. Hillman, New Haven
Clayton H. Hitchins, New Haven
Samuel A. Jaffe, New Haven
Mary L. James, North Haven
Robert H. Jordan, New Haven
Lester G. Joseph, New Haven
LeMoyne C. Kelly, Waterbury
John J. Kennedy, Jr., Windsor Locks
Leo W. Koster, West Haven
Henry Krochmal, Meriden
Samuel D. Kushlan, New Haven
Michael H. Lavorgna, New Haven
Maxwell Lear, New Haven
Jerome A. L'Heureux, Meriden
J. David McGaughey, III, Wallingford
J. Wister Meigs, New Haven
Anthony J. Mendillo, New Haven
Henry Merriman, Waterbury
W. Haviland Morriss, Wallingford
Harold F. Morrill, Waterbury
Thomas P. Murdock, Meriden
Richard Newman, New Haven
Edward W. Oxnard, Cheshire
Else Pappenheim, New Haven
Gioacchino S. Parrella, Milford
Louis A. Parrella, North Haven
Harry F. Pennington, Meriden
Samuel Philipson, New Haven
George J. Piazza, New Haven
John P. Riesman, New Haven
Milo P. Rindge, Madison
Orville F. Rogers, New Haven
Benjamin B. Rosenthal, Milford
Allan J. Ryan, Meriden
A. Lewis Shure, New Haven
Jasper H. Smith, Waterbury
John S. Staneslow, Waterbury
Harold Strickland, Meriden
Morgan Y. Swirsky, New Haven
Wilder Tileston, New Haven
Alexander B. Timm, Jr., Milford
Leo L. Tylec, Naugatuck
J. Alexander VanHeuven, New Haven
Paul Vestal, New Haven
J. Alfred Wilson, Meriden
Paul Winer, New Haven
Arthur M. Yudkin, New Haven

NEW LONDON COUNTY

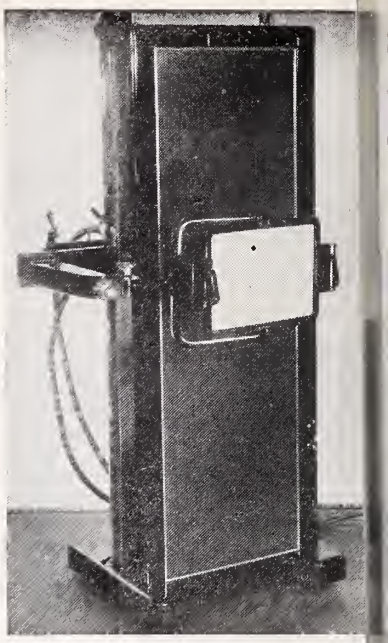
Mario J. Albamonti, Norwich
Henry A. Archambault, Taftville
Frederick C. Barrett, Jewett City
Harold A. Bergendahl, Norwich
Frederick J. Fagan, New London
Phylis P. Frost, Rochester, New York
Louis Guss, Norwich
Frederick B. Hartman, New London
Robert T. Henkle, New London
Morris E. Katz, Norwich
Winfield O. Kelley, Norwich
Warren W. LaPierre, Norwich
Joseph J. Mahoney, Norwich
Frank J. Miselis, Uncasville
Martin L. O'Neil, Jewett City
David G. Rousseau, Taftville
Thomas Soltz, New London
Richard M. Starr, New London
John W. Suplicki, Norwich
Paul Sutton, Groton
S. Paul Tombari, Waterford
Harold D. VonGlahn, Old Lyme
Carl H. Wies, New London

TOLLAND COUNTY

Seymour I. Kummer, Rockville
Wendelin G. Luckner, Stafford Springs
Elliott H. Metcalf, Rockville

WINDHAM COUNTY

Gerard M. Chartier, Danielson
Ralph Gilman, Storrs
J. Arthur Girouard, Willimantic
Angelo J. Gulino, Plainfield
Winston C. Hainsworth, Willimantic
Mervyn H. Little, Willimantic
Olga A. G. Little, Willimantic
James W. Major, Willimantic
Sawyer E. Medbury, Willimantic
Richard V. Newcombe, Willimantic
Edward J. Ottenheimer, Windham
Karl T. Phillips, Putnam
Brae Rafferty, Willimantic
William M. Shepard, Putnam
Nathan Spector, Willimantic
Jean K. Stevenson, Thompson
Bruce R. Valentine, Abington
John A. Woodworth, Moosup



when you are looking

. . . for dependable service and a complete line of medical equipment — call

American Surgical

Available — to you —

X-ray servicing on all types of Equipment.

Radiologic Technique Instruction.

Repair of Equipment.

Installation.

md EC

of floor space, provides both radio fluoroscopic facilities in a smartl and compact unit.

Available in four distinctive exe apparatus may be purchased in 15, milliampere capacities commensura requirements of your practice. Wh cated, the power of the Economy be increased by interchangeable co

American Surgical

SUPPLY AND EQUIPMENT COMPANY : 1715 BARNUM AVE. :

the COMBINATION FLUOROSCOPE

The Combination Fluoroscope extends beyond the operating sphere of the normal fluoroscope and through a pivoting arm which suspends the tubehead—brings the added facility of horizontal as well as vertical radiography to the operator. The unit is completely shockproof and provides ample maneuverability for all general x-ray examinations.

Like others in the Economy Series, the Combination Unit is available in four types.

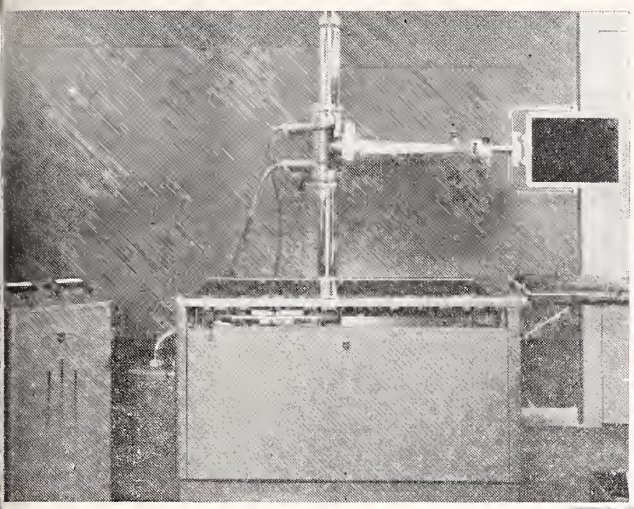
Self-contained generators are available with either 15 or 30 milliampere output, rated as follows:

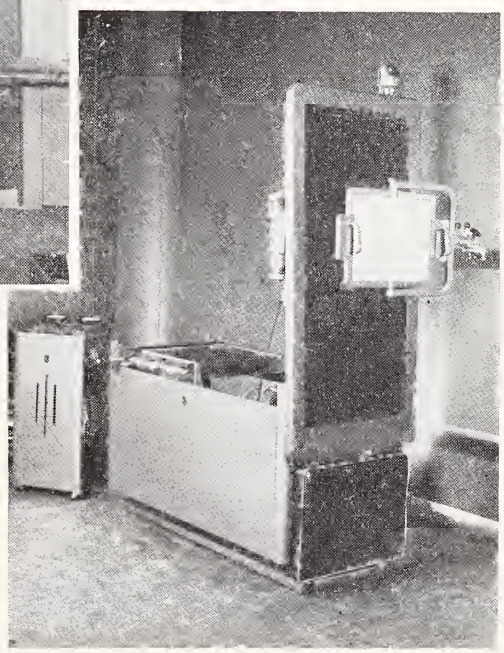
15 MA at 80 KVP or 30 MA at 90 KVP
5 MA at 80 KVP or 5 MA at 80 KVP

The self-contained head may be replaced by a cable connected x-ray tube and high-tension transformer for increased energy ratings as follows:

50 MA at 85 KVP or 100 MA at 85 KVP

Maximum height overall	80 inches
Maximum width overall—arm extended	53 inches
Maximum extension of tube—over table	23 inches
Vertical travel of screen and tube (max.)	53 inches
Horizontal travel of tube	9 inches





Y MASTER, requiring a minimum

The Economy Master table is one which may be used in the doctor's office for general utility or as an examining table. In the Economy Series, newest addition to the North American Phillips line, apparatus operation has been greatly simplified requiring least possible effort on the part of the operator. Changeover from horizontal to vertical position for either fluoroscopy or radiography can be accomplished in a moment.

If you wish our representative to call PHONE 5-3116 or ENTERPRISE 3190 . . . or fill in the inquiry slip and mail it today.

The American Surgical Supply and Equipment Co.
Bridgeport, Conn.

Gentlemen: Kindly have your representative call on

Date..... Time.....

I am interested in: Combination Fluoroscope ☐ Economy Master ☐

Dr. .....

Address .....

.....

OX 150 : BRIDGEPORT

THE HISTORIAN'S NOTE BOOK

A NOTE ON INOCULATION FOR SMALL-POX IN COLONIAL NEW ENGLAND

Arthur S. Brackett, m.d., *Bristol*

We are all so familiar with vaccination against smallpox that it seems as if it had been with us always; and when we are told that inoculation was practised for centuries before vaccination was introduced in 1796, we are amazed.

Inoculation was practised for centuries in various countries in Asia and Africa. Except among the Chinese, inoculation has meant introduction of matter taken from a smallpox pustule into the body of the patient through scratches or incisions. This produced real smallpox, but usually in a mild form. Among the Chinese the crusts of the pustules were ground up and inserted into the nostil—if a boy, into the left nostril, if a girl, into the right!

Inoculation was introduced into England early in the eighteenth century by Lady Mary Wortley Montague from Constantinople, where her husband was British Ambassador to Turkey. Lady Mary had observed a custom of the Turkish women of gathering in parties with their babies to have old women scratch the babies with needles and apply matter from smallpox pustules. How this method was discovered, or what their theories were, we do not know, but it is certain that many severe cases were prevented and many lives saved.

The subject of inoculation had been agitating aristocratic and scientific circles ever since Lady Mary had had her own son successfully inoculated in 1718. Later the Royal children were inoculated, which did much to popularize the method. Two hundred years ago smallpox was a terrible scourge and in Europe a tenth of the deaths was caused by it.

During the eighteenth century, however, discoveries were made which have made it possible to eliminate smallpox. About 1775 Dr. Edward Jenner of Gloucestershire, England, learned that there was a belief among dairymen that milkmaids who had had the cowpox were immune to smallpox. In 1796 Jenner infected an eight year old boy named Phipps with matter taken from a sore on the hand of a dairymaid who had cowpox. A month and a half later Jenner inoculated young Phipps with matter immediately after taking it from a pustule of a smallpox patient. No disease followed. Several months afterwards Jenner inoculated Phipps again, but he was still immune. Jenner did not repeat this experiment until 1798 because cowpox was not prevalent in his neighborhood in 1797. In 1798 he repeated the experiment in several individuals, and also tried to infect other individuals who had had cowpox some years previously. In each case the immunity induced by the cowpox protected the individual from smallpox. Later in 1798 Jenner published his famous "Inquiry" in which he announced his discovery. This new method was called kine-pox inoculation, and later, vaccination, from the Latin word *vacca*, a cow.

Vaccination was at first supposed to give immunity for life, but actually, in many cases, it was for not more than ten years. Vaccination came into competition with inoculation because it was safer and less expensive and the patient could keep on working. For several years the two methods were used contemporaneously.

The attempt to eliminate smallpox has been a grim fight, but it has had its amusing incidents, one of which I found through reading of a dispute between Dr. Benjamin Gale and Mr. Thaddeus Burr.

In the fall of 1950 I was in Durham, England, and after visiting the Cathedral I strolled into a nearby antique shop. On a shelf of old books was one made up of five numbers of *The Universal Museum and Complete Magazine* for July through November, 1766, which I bought. This monthly magazine published information about current events, foreign and domestic politics, reviews of medical developments, reflections on religion, and articles of public interest.

In these issues there were two reviews on inoculation against smallpox, the methods in New England and in China. The headline of the article on the method in New England reads, as reported by the abridger, "Particular Account of the present Method of Inoculation, with Remarks, from a Pamphlet just

published." This article was compiled by some unknown person, apparently not a doctor, from a paper by Dr. Benjamin Gale of Killingworth, Connecticut, which had been published in the *Transactions of the Royal Society,* (vol. 55, p. 1765).

Dr. Gale was among the leaders advocating inoculation, others being Dr. John Huxham of England and Benjamin Franklin of Philadelphia, Fellow of the Royal Society of London. Dr. Gale was born in 1715 in Jamaica, Long Island. He was graduated from Yale in 1733 and took up the study of medicine at Killingworth, Connecticut, under the Rev. Jared Eliot, who was said to have been the leading physician in Connecticut and who trained several prominent physicians. Gale married his daughter, Hannah Eliot. Gale wrote many papers, including one on the "Bite of the Rattlesnake." Later he received a medal from the London Society of Arts, was elected a corresponding member of that society, wrote many other articles on a wide variety of subjects and was elected to the General Assembly of Connecticut for 32 years, when he declined reelection.

Thaddeus Burr, a grandson of Chief Justice Peter Burr, was born at Fairfield, Connecticut, August 22, 1735. "Mr. Burr was the possessor of a large estate, a graduate of Yale College, and a friend of New England's leading citizens and statesmen. He served with honor in many places of trust and responsibility as a selectman, justice, deputy, postmaster, member of the War Committee, High Sheriff, member of the Governor's Council, member of the Constitutional Convention, and presidential elector."[1]

Dr. Gale and Mr. Burr must have often been thrown together while working hard in the fight for liberty during the Revolutionary War and probably learned to appreciate one another's good points; but in 1764 when Dr. Gale wrote his Dissertation which the abridger blundered in reporting, they had never met and they were both irritated over a minor misunderstanding.

Gale's Dissertation, published in the *Transactions of the Royal Society* and read by Dr. Huxham before a meeting of the Society in 1765, was entitled "Historical Memoirs relating to the practice of smallpox inoculation in the British American Colonies, particularly in New England." In this article, Gale states that in previous epidemics in Boston and vicinity 70 or 80 people were successfully inoculated with only one death resulting. But after putting the patients on a preparatory dietary regimen and using antimony and mercury before inoculation and during the ensuing smallpox, the proportion was one death out of 800. Gale had become an enthusiastic convert to this method, following Boerhaave of Leyden and Adam Thomson of Philadelphia. Gale's article was read by the abridger of the *Universal Museum and Complete Magazine,* who mistakenly ascribed to Gale's private practice the large number of those successfully treated (800 to 1).

In going through the early files of the *Connecticut Courant,* looking for advertisements of inoculation hospitals in Connecticut, I happened to run across an attack on Dr. Gale by Mr. Thaddeus Burr of Fairfield, and in the same issue (June 26, 1769, No. 236), Gale's reply.

It would seem that previously there had been ill feeling between them (though they had never met), so when Burr read the incorrect abridgment he assumed that Gale had claimed to have inoculated 800 in his private practice with the loss of only one. Sarcastically Burr writes, "Had I followed the example of the modest Dr. and taken pains to have sent abroad false and exagerated accounts of my natural abilities perhaps they would have appeared as conspicuous as his. That he may not evade the charge, I will give the publick the following extract from the *Universal Museum* for the year 1766, page 333, viz. 'It appears on the authority of Dr. Huxham that Dr. Benjamin Gale, of Connecticut, in New England, since he has given Mercury antimony in preparing persons for inoculation, has lost only one of eight hundred inoculated: whereas before he gave this medicine, he usually lost one patient out of one hundred.' As soon as I met with this account, which was not long after the *Museum* was published, I asked a gentleman who was a pupil of the Dr.'s about the time that the new method of inoculation was introduced, how many persons Dr. Gale had ever inoculated? He told me, he did not know exactly, but would venture to say not more than seventy: They who are best acquainted with the Dr. and his practice in inoculation, must judge of the truth of his account."

Dr. Gale's reply in part follows.

"To the Public.

"Wherefore KNOW YE,

"Mess's Thadeus Burr, J. S. his private *Secretary*, R. W. and E. D. his *Assistant Councillors*, & all others whom it doth or may concern. That having wrote a dissertation on the American method of

Inoculation to which I prefix'd some historical memoirs of the success of Inoculation in the town of *Boston,* at three different periods of time, the *first* A. D. 1720 by Dr. *Boylston,* the 2d 1752, the third 1764, after the use of Mercury was introduced into practice, the first I extracted from Dr. *Douglas* his history, the second and third from authenticated accounts, under the hands of the selectmen of the town of *Boston,* all which I transmitted to Dr. *Huxham* of *Plymouth* in *Great Britain,* which he caus'd to be read before the *Royal Society,* and was printed at large in the philosophical transactions, for the year 1765, and from thence abridg'd, and the blunder of the abridger, was copied by the authors of the Magazine and Universal Museum. Immediately on my seeing the Magazine, not knowing my dissertation was published in *London,* I wrote Dr. *Huxham* requesting him to correct the error, inclosing the same to Dr. *Franklin* F. R. S. then in *London,* soon after I had forwarded the same, I receiv'd a letter from Dr. *Huxham,* of which the following is an extract.

" 'Plymouth, December 15, 1766

" 'Dear Sir,

" 'In the spring of the year 1765, I laid your dissertation on Inoculation for the Small Pox, &c. before the Royal Society, who receiv'd it well and ordered me to return you their thanks for the communication, in the last volume of the Philosophical transactions (No. 55, for the Year 1765) which was published last summer, the whole of your dissertation was inserted, which is seldom done, unless the society judge it well merits the public attention, &c &c.

" 'John Huxham.'

"In May 1767 I receiv'd a letter from Dr. Franklin, dated London, Feb. 23d, 1767, of which the following is an extract.

" 'Dear Sir,

" 'I receiv'd your favour of Nov. 15, with a letter inclos'd to Dr. *Huxham,* relating to a mistake in the account given of your success in inoculation, as printed in the Gentleman's Magazine of August last, which seems to give you great uneasiness. It seems you have not known that your letter to Dr. *Huxham,* concerning inoculations in *New England,* was read at the royal society the 23d of May, 1765, & is printed at full length in their transactions, Vol. LV for that year, it there appears that you give the accounts of the success of Inoculation, *without* and *with* Mercury, viz. 1 in 80 or 100 *without,* and 1 in 800 or 1000 *with* Mercury, as accounts receiv'd from *Boston* about the time of your writing. viz in 1764, and not as accounts of your own practice, of which in the last Paragraph you expressly speak, as being so small, that it was unnecessary to mention your method, as you had not opportunity to Inoculate no more than 70 or 80 persons before Inoculation was wholly interdicted by the legislature of the colony, that you see in the Magazines are only abridg'd accounts or notes of what is contained in that volume, these abridgers often make such mistakes, which nobody regards & as the account stands right, in the only authentic publication, the *transactions;* I think it needless to give Dr. *Huxham* the trouble you request him to take of contradicting the Magazine, therefore as you leave it with me, to seal and forward your letter to him or to suppress it, as I might think proper, I have chosen the latter, which I hope you will approve, &c. &c.

" 'Ben Franklin'."

Continuing his reply Dr. Gale wrote, "As Mr. Burr has attacked my character in a point of so delicate a nature, I hope my publishing these letters will not offend Dr. *Franklin,* to whom I am under the greatest obligations, or incur the censure of the public; and have lodged the original letters with the Printers hereof, for the inspection of any who may doubt of their being genuine, and shall only add, that as I was never honored by an acquaintance with Mr. *Burr,* nor have ever given him any private offence, as he has been induc'd to inlist a VOLUNTEER in a service, I conceive intirely out of his sphere, the public must conclude it is merely to disgorge the venom of his *party,* & at the same time to vent his own *personal pike,* at two hon. gentlemen by far his superiors, who perhaps may never have merited his resentment, and as he must be deemed the aggressor, if he should not kindly receive the gentle reproof I have given him, and should again transgress, I hope the public will excuse me, if I treat him more freely than I hitherto have done, unless I should be prevailed with by the solicitations of my friends, to disregard his future productions as unworthy my Notice and regard.

"Benjamin Gale."

Note that Franklin in his reply to Gale quotes the *Gentleman's Magazine* of August, 1766, instead of the *Universal Museum and Complete Magazine* of July, 1766. What Franklin read was a review of a paper by Dr. George Baker entitled "An Enquiry

into the Merits of a Method of Inoculating the Small-Pox (London, 1766)," which was published in the *Gentleman's Magazine*, XXXVI, 381-383, (August, 1766). It reads as follows: "Several physicians of credit, and among the rest Dr. Andrews of Exeter, insist strenuously on the good effects of calomel given before inoculation, and it appears, upon the authority of Dr. Huxham, that Dr. Gale of Connecticut in New England, since he has given mercury and antimony as preparatory medicines, has lost only one patient out of 800, whom he has inoculated, tho' before he usually lost one out of a hundred."

Note that both abridgers made the same mistake.

While Gale was writing his Dissertation, Boston was undergoing one of its recurring epidemics of smallpox, and the physicians were trying out the new "American method" advocated by Adam Thomson, Gale, and others.

The truth of Gale's claim is proved by a dispatch from Boston which was published in New London, Connecticut, March 30, 1764 in the *New London Gazette*. "Boston, March 26, 1764. We have the pleasure to inform the Public, That the new Method taken in Practice of Inoculation, has been favour'd with the most surprising success:—By the best Accounts we have been able to collect, between two and three thousand Persons in this Town only, have taken the Distemper in this Method, near one half of which Number have already recover'd of the same, most of whom have had it in the lightest manner, and we do not hear of one inoculated Person that has died except two Infants, who died in Fits . . . The Poor of the Town have almost all come into this Method, and by the kind Care of the Overseers, and the generous offers of the Physicians to tend them gratis, the greatest part of them are already Inoculated; and it is thought that the Infection in Town is so very small, that the Goods in the Stores and Shops can no way receive it, and there is great Reason to hope the Town will soon be clear of the Small-Pox. (What a great Mercy is it that a Method is found out to mitigate the violence and malignity of a Distemper which has carried off so great a part of the human Race in all Ages, and which this Town have in times past felt the melancholly effects of!)"

Later dispatches to the *New London Gazette* reported the progress of the epidemic. "Boston, April 2. To the Printers. Surely the town is vastly indebted to the Great Lord of the Universe and a tribute of praise is justly due to Him whose watchful Eye has compassed our path and our Bed. The Pestilence which has formerly scattered ten thousand poisons from his baleful wings, tainted the air, infected and depopulated the town with inevitable destruction, whose angry Countenance has spread Desolation and destruction to the inhabitants seems now to be disarmed of its malignity through the interposition of a Kind Providence.

"Not less than 3,000 persons have been inoculated for the smallpox since the 8th of March last: 2,000 at least have recovered & the others are in a fair way. Not more than 5 have died and they children under a year old with *other infirmities*."

"Boston, April 9. The smallpox spread to Charlestown & the selectmen gave leave to have inoculation. In Boston out of the great number inoculated at Castle William and Point Shirley none died."

A later dispatch stated that an old woman 95 years old, who had been inoculated successfully, gave as her reason for having the operation that she would not now be inconvenienced by having to leave the town every ten or twelve years!

Regarding the controversy over the truth of Gale's report, we may conclude that Burr was wrong, Gale was right, and the abridgers blundered. But was Gale also correct in claiming that the giving of mercury and antimony before and after inoculation caused the difference between a mortality of one out of 80 and one of 800? Gale's opinion is supported by that of the Boston correspondent of the *New London Gazette*, as well as by the experience of Boerhaave, Adam Thomson, Huxham, George Baker, and other American physicians. The treatment appeared successful enough to establish it as the standardized practice of that day in this country. It was abandoned, of course, when vaccination replaced inoculation.

The possibility that there was a difference in mortality from inoculation with and without the use of mercury and antimony leads me to ask whether these two elements might be helpful in other viral diseases, for example, in viral pneumonitis, poliomyelitis, etc.? Our experiences with vitamins and antibodies have shown that anything manifestly not hopeless should be tried, especially if it can be tried with so little expenditure of time, trouble and experience.

REFERENCE

Chapter One, Sketches, Connecticut Daughters of the American Revolution. Edited by Mary Philotheta Root, A. B. "Eunice Dennie Burr" by Frank Samuel Child, p. 65.

AMA: CHICAGO: JUNE 9-13, 1952

Registration Over 14,000 . . . Hartford Physicians Get Honorable Mention . . . Paul White of Boston Honored . . . President Bauer Blasts Government Domination . . . HR7800 Condemned . . . High Taxes Hit . . . AMA Fellowship Abolished . . . American Medical Education Foundation Grows Rapidly . . . Mrs. Sally Tracy National Auxiliary Officer . . . Dr. McCormick of Toledo the New President-Elect.

With a registration of over 14,000 physicians in Chicago, that city acted as host to the 101st annual session of the American Medical Association last month. Well named the crossroads city of our Nation, there gathered there from outside the United States representatives from Canada, Africa, Australia, Argentina, Bahamas, Belgium, Brazil, China, Columbia, Cuba, Denmark, England, Finland, France, Germany, Greece, Guatemala, Iran, Israel, Italy, Ireland, Mexico, New Brunswick, New Zealand, Nova Scotia, Norway, Pakistan, Peru, Siam, Sweden, Switzerland and Uruguay. What national medical organization but ours could draw such an array of medical friends! From the opening address of retiring President John W. Cline, with his masterful resumé of the battle waged against government control of medicine in the last two years, to the close of the last scientific lecture it was a memorable session.

Housed at the Navy Pier were the scientific exhibits and technical exhibits and there was held the scientific program consisting of demonstrations, lectures, television and radio presentations. True, the Navy Pier is an endless footpath for the weary walker and may be almost unbearable on a hot day. It boasts no running water and no restaurants but spread out for a goodly mile there is ample elbow room and plenty of space for contemplation. Facilities at Atlantic City and San Francisco unfortunately leave Chicago's Navy Pier far behind.



Retiring President John W. Cline

SCIENTIFIC EXHIBITS

Connecticut looked with pride upon its two exhibits, one, An Experimental Study of the Etiology and Pathogenesis of Arterial Disease presented by Waters, De Suto-Nagy, and McAllister of Yale University School of Medicine; the other, Blood Volume Determination as a guide to Intravenous Therapy Experiences of a General Hospital by Tennant and Barbour of the Hartford Hospital. Then we found Barnett Greenhouse of New Haven participating in the diabetic conference where he led the discussion on Diet and NPH Insulin in General Practice. J. Whitfield Larrabee of Hartford served as one of the demonstrators in the Special Exhibit on Fractures.

Particularly striking were the various cardiac and vascular exhibits, the exhibit on Aviation Ophthalmology, and the very practical exhibit illustrating a wide variety of diagnostic therapeutic procedures that can be done by a general practitioner with adequate equipment and capable auxiliary personnel but without a hospital. Maurice H. Cottle of Chicago, who recently conducted a three day clinic

at Hartford Hospital, presented an excellent exhibit on Progress in Rhinology. Finally, one could not overlook the excellent exhibit by Dr. Rusk and others depicting self-help devices and home facilities for physically disabled women. Adjacent to this was a model kitchen, full-size, set up to demonstrate work simplification for cardiac women.

PRIZE WINNERS—SCIENTIFIC EXHIBITS

A Gold Medal for "originality of investigation" was awarded a group from St. Clare's Hospital, New York City, for their exhibit on Surgical Anatomy of the Portal System. The second gold medal "for excellence of correlated facts and presentation" went to a group from the Mayo Clinic for their exhibit on Pheochromocytoma, A Cause of Hypertension—Diagnosis and Surgical Treatment.

In the first category—called the Hektoen Medal—the Silver Medal was awarded a group from the Cleveland Clinic for their exhibit on Systemic Lupus Erythematosus, The Hektoen Bronze Medal went to a group from Hahnemann Medical College and Hospital, Philadelphia, and St. Michael's Hospital, Newark, N. J., for the exhibit on Arteriolization of the Coronary Sinus.

In the second category—called the Billings Medal—winner of the Silver Medal was Ernest C. Faust of Tulane University, New Orleans. Bronze Medal in this category was awarded a group from Hahnemann Medical College and Hospital, Philadelphia, for their exhibit on Cardiac Asystole.

Six presentations were singled out for Special Commendation. They were the Symposiums on Overweight, Cardiovascular Diseases and Diabetes, and the special exhibits on fractures, pathology and artificial respiration.

In the Section prize winners Honorable Mention was accorded Robert Tennant and Charles M. Barbour of Hartford Hospital for their exhibit on Blood Volume Determinations in Intravenous Therapy.

TECHNICAL EXHIBITS

The usual free cigarettes, hand lotions, soft drinks, shaving cream and a chance on a Cadillac made the 1952 edition of technical exhibits little different from its predecessors. Missing was the Ethicon ranch house and the constantly be-rolled Sealy Mattress, but in place of the latter Sealy had a smaller demonstration of the action of their box spring. The new aseptic surgical camera was on display, likewise many refinements in a variety of surgical instruments and equipment. Elsie, the Borden cow, was missing, and in her place, believe it or not, two young artists actively engaged in sketching two, not too young, physicians, while the real attraction, a charming young blonde, served chocolate milk to passers by.

DR. PAUL D. WHITE RECEIVES AMA CITATION

The House of Delegates selected Paul Dudley White of Boston to receive the 1952 Distinguished Service Award. Dr. White richly deserves this honor. Well known to the physicians of Connecticut, his fame is worldwide for he has trained physicians in the diagnosis and treatment of heart diseases in scores of nations. Dr. White is one of the fathers of cardiology. His book on heart disease is rated as one of the most outstanding contributions in this field. Then, too, Paul White is a kindly physician,

REGISTERED FROM CONNECTICUT

Vincent Balleto, East Haven
Charles M. Barbour, Jr., Hartford
Paul H. Barbour, Farmington
Creighton Barker, New Haven
Harold S. Barrett, Hartford
Eugene C. Beck, Norwalk
David H. Bluestone, Naugatuck
L. A. Chotkowski, Kensington
Thomas J. Danaher, Torrington
Ilona K. DeSuto-Nagy, New Haven
Barnett Greenhouse, New Haven
Albert E. Herrmann, Waterbury
W. H. Horton, New Haven
Joseph H. Howard, Bridgeport
Anthony D. Intriere, Greenwich
Carl E. Johnson, New Haven
Aaron Levinsky, Bridgeport
Robert I. Lowenberg, New Haven
Benjamin E. Lyons, Norwalk
Stevens J. Martin, Hartford
George W. Mast, Ridgefield
D. Olan Meeker, Riverside
Royal A. Meyers, Watertown
Thomas P. Murdock, Meriden
E. J. Orbach, New Britain
Stanley H. Osborn, Hartford
A. Della Pietra, Hartford
Foster E. Priddy, Wethersfield
M. L. Riccitelli, New Haven
Benjamin Sherman, Bridgeport
Daniel E. Shea, Hartford
Homer B. Shoup, Jr., Westport
Mark Solomkin, Hartford
E. Myles Standish, Hartford
Robert Tennant, Hartford
Marcel Thau, Hartford
F. Erwin Tracy, Middletown
Benedict Vicas, Hartford
Charles K. Wallace, Hartford
LeRoy H. Wardner, Hartford
L. L. Waters, New Haven
Richard C. Whiting, Hartford
Stanley B. Weld, Hartford
Winfield E. Wight, Thomaston
Ralph C. Wright, New Britain

Member of Board of Trustees of AMA

Thomas P. Murdock, Meriden

Chairman of House of Delegates Reference Committee on Medical Military Affairs

Joseph H. Howard, Bridgeport

interested in human beings and particularly in his patients. It was a very satisfying sight to see the wiry little man—a great walker and an ardent camper—stand up before a packed house and receive this honor bestowed by the hands of his friend and former pupil, retiring President John W. Cline.



President Louis H. Bauer

THE CALL TO ACTION

Beginning with the Conference of Presidents and other Officers of State Medical Associations on the day preceding the opening of the AMA session and continuing through to the final adjournment of the House of Delegates, medicine received one summons after another to push forward in its fight for freedom. The impetus came from Allan B. Kline, president of the American Farm Bureau Federation, who pointed out the manner government is encroaching on personal liberty. Clarence Manion, dean of Notre Dame University Law School, took up where Mr. Kline left off when he said, "Americans, under the swelling government of the United States, have become morally sick." . . . "A swelling is evidence of sickness underneath. Only when the people's faith in God is restored to proportions described in the Declaration of Independence will government be reduced to the simple tasks marked out for it when the Republic was born. Every citizen has a responsibility in this matter which is serious in the extreme."

Then at the close of the Presidents' Conference Congressman Judd of Minnesota came to the defense of his confreres of four years ago when he said: "We balanced the budget! We paid off the debt! And what happened? I was the only Republican across the northern stretch of the United States who survived the election! And where were you?—Fishing."

DR. LOUIS H. BAUER TAKES OFFICE AS PRESIDENT

It took the newly elected President of the American Medical Association to sound the clarion note which rang all through the sessions of the House of Delegates. Inaugurated in the ballroom of the Palmer House as President for the coming year, Dr. Louis H. Bauer of Hempstead, Long Island rose to the occasion with words that will be remembered by those present and by the millions of people of the United States listening in on two of the nationwide hook-ups. "During the entire history of the American Medical Association," said Dr. Bauer in reply to critics of the AMA for reactionary obstructionism, "with just one exception, there has been no major Federal health law enacted that was not either sponsored or supported by the Association." After recounting the accomplishments of the AMA in recent years, he continued: "Unfortunately there are a few physicians who are not a credit to their profession. They consider the practice of medicine as a means of financial gain and that alone. Such individuals should be driven out of their Medical Societies."

Government control of medicine came in for its share of criticism. "Sufficiently aroused," said Dr. Bauer, "the American people can bring to a full stop the pellmell retreat from fundamental American principles. But they cannot do it if they don't vote. It is a shameful fact that in the last Presidential election barely 51 per cent of the eligible voters exercised their right of suffrage." . . . "The great decision—Socialism or Americanism—must be made by the people. And it must be made by ALL the people." . . . "Not only are we faced today with corruption in Government, but with an attempt to destroy everything on which this nation was built and which has made it great."

Then, with his eye on the coming election, he continued: "It is the task of our two major political parties, and their leaders, to see that the people of the United States are given a Government that serves, rather than a Government that dominates."

. . .

"Whatever our party affiliations, we must examine closely the policies professed by every candidate. Neither straddling nor flamboyant evasion must be allowed to sway us. We must demand straightforward honesty, frankness and sincerity in our candidates. Only in this way can we be sure that we shall have a Government that represents the true will of the people."

His closing words should be an inspiration to every physician in the United States. "I am proud to be a member of the American Medical Association which has spearheaded the fight against the socialism that is creeping over this country. I am proud to be the leader of the Association during the coming year. But, most of all, I am proud to be an American citizen and I intend to do all in my power to carry out the concluding pledge of my oath of office—to champion the freedom of medical practice and freedom for all my fellow Americans."

OPINION ON TRUMAN HEALTH COMMISSION POSTPONED

The House of Delegates postponed expression of opinion on the President's Commission on the Health Needs of the Nation headed by Dr. Paul B. Magnuson. The report is not to appear until December, 1952 and until then no judgment is to be passed by the AMA. The reference committee report on resolutions relating to this Commission strongly supported the Board of Trustees "for the restraint that had been shown regarding some of the statements that had been attributed to Dr. Paul B. Magnuson in the past." The reference committee expressed its belief that the Board of Trustees is acting correctly in not attempting to answer every criticism by individual members of the medical profession. It also upheld the Trustees in pointing out certain inaccuracies and misstatements made concerning the Board of Trustees and officers of the AMA and the Association itself. There was an abundance of heated discussion.

HR7800 CONDEMNED

An amendment to the Social Security Act, HR7800, was severely condemned by the Board of Trustees and in turn by the House of Delegates. A resolution introduced at the last session in Chicago expressed strong disapproval of the amended version of Section Three of the new bill, dealing with the powers of the Federal Security Administrator, Oscar R. Ewing, in cases of permanent and total disability.

The American Medical Association objected to the original bill on the grounds that Section Three "would vest in the Federal Security Administration broad powers over the medical profession." Following rejection of the original bill on May 19, certain amendments were made by the House Ways and Means Committee, that its sponsors say, eliminate the features objected to by the AMA. This was strongly challenged in the resolution adopted here this afternoon.

HOODWINKING CHARGES

"Notwithstanding certain deletions in Section Three," the resolution asserts, "the fundamental purpose of this bill to extend the power and authority of the Federal Security Administration remains unchanged, and the deletions which have been made are only another attempt to hoodwink the public into believing the section is completely altruistic."

Section Three of the original measure, the House of Delegates was informed, "provided for the introduction of a new theory in the Social Security program which in its implementation could result in the socialization of the medical profession, inasmuch as it would provide that the Social Security Administrator would (A) determine what constitutes permanent and total disability; (B) establish the types of proof necessary to establish permanent and total disability; (C) provide by regulation when and where physical examinations should be taken; (D) be authorized to prescribe the examining physician or agency (including Federal installations); (E) establish the fees; (F) be authorized to pay travel expenses and subsistence incident to the taking of such physical examinations, and (G) have power to curtail old age and survivors' insurance benefits because of noncompliance with regulations of this section."

"The defeat of HR7800 (the Social Security bill), depriving social security beneficiaries of numerous additional benefits," the resolution states, "was a direct result of the Truman Administration's attempt to play politics by tying in a socialized medicine scheme with an otherwise popular measure.

"The American Medical Association condemns the breech of faith by this Administration with those who would benefit from this bill in a flagrant attempt to railroad through a provision to aid in the socialization of medicine, which could not possibly be adopted if considered openly and fairly.

"The American Medical Association urges that Congress re-refer this bill to the committee where it should be subject to the ordinary democratic processes of legislation."

COMMITTEE TO STUDY OSTEOPATHIC EDUCATION

The House of Delegates passed on to the Board of Trustees a request that the latter appoint a committee to study and consult with the American Osteopathic Association in regard to osteopathic education. President Cline in his retiring speech urged that the two associations work more closely together on various aspects of education for students of osteopathy. This is not a new subject in the House of Delegates. The osteopaths have previously requested that the two associations get together but have been turned down. It is true that in about 30 states the licenses granted to osteopathic physicians approach or approximate, for practical legal purposes, those granted to doctors of medicine. We may soon find the latter teaching in osteopathic schools without being considered unethical.

FEDERAL MEDICAL SERVICES

There were several resolutions introduced into the House of Delegates pertaining to federal medical services. These included consideration of legislation favoring medical and hospital benefits for dependents of service personnel, the question of the medical care of nonservice connected disabilities among veterans, etc. These were all referred to a special committee now engaged in a study of these problems. However, the House did go on record as opposing the acceptance of veterans with nonservice connected disabilities to VA hospitals where insurance was carried by the veteran and collected by the hospital.

HIGH TAXES HIT

The House of Delegates went on record favoring a Congressional amendment to the constitution limiting the taxing power of the federal government. Physicians were urged to accept their responsibilities as citizens and actively participate in all matters at local, state and national levels that will help preserve the principles of American government.

The House further pursued its interest in affairs not strictly medical by approving a resolution favoring an amendment to the constitution to prevent the adoption of any treaty which will conflict with our constitution.

FELLOWSHIP IN AMA ABOLISHED—DUES SET

By an amendment to the constitution of the AMA the classification of Fellows has been abolished so that the types of members are now classified as active, associate, service, affiliate and honorary.

The dues for 1953 were set at $25, this to include a subscription to the *Journal of the AMA*, or instead, if desired, to one of the specialty journals published by the AMA.

The New Jersey delegation introduced a resolution calling for an increase in commission paid by the AMA for collecting the latter's dues, or a release from this duty. This matter of collection of AMA dues was referred to the Board of Trustees for study. Likewise the Board received another problem for study and solution, viz., the confusion in classification of membership in the various State Societies.

SPECIALTY BOARDS FOR THOSE NOT M.D.'S

Opposition was expressed in a resolution to the formation of the Board of Microbiology since this category includes those not doctors of medicine. Another resolution opposed the certification of clinical psychologists for a similar reason. The Council on Medical Education and Hospitals is to undertake a study of this whole problem of non-physician specialty boards.

It was voted to confer with the Board of Oral Surgery with a view to securing a clear definition of the exact scope of those certified by this board.

INTERN AND RESIDENCY PROGRAM

To the Council on Medical Education and Hospitals was assigned the task of studying the present method of establishing residencies and internships for the purpose of remedying the present imbalance between supply and demand.

A resolution was approved opposing the establishment of any system whereby time spent in an internship in a military hospital would be credited toward one's total military obligation.

MISCELLANEOUS ACTIONS OF HOUSE OF DELEGATES

A request was sent to the Board of Trustees asking for reactivation of the Committee on Motor Vehicle Accidents.

Approval was voted of a resolution calling for no organized support of any political party or of any candidate for public office by members of the American Medical Association.

It was voted that hereafter the selection of the candidate for the General Practitioner Award be made by an anonymous committee of three selected by the Board of Trustees.

The Council on Constitution and By-Laws has been directed to make a study of the Code of Ethics.

The Board of Trustees was commended for its support of the Reed-Keogh bill and asked to continue its efforts.

The apathy of physicians in the Civilian Defense program was decried.

A resolution was passed discouraging the realizing of a profit by some hospitals in which are established blood centers, this profit being used for meeting other hospital expenses.

GIFTS TO EDUCATION FOUNDATION

A round of applause greeted an announcement that the Woman's Auxiliary had contributed $10,000 to the American Medical Education Foundation. The physicians of Chicago and Illinois are contributing over $200,000 this year. Dr. Elmer Henderson reported gifts to the Foundation ahead of those received last year at this time. A $1,000 club is being formed with a charter membership of eight physicians. The suggestion was made that there also be formed a $100 Club to encourage an annual gift of this amount for life. The Foundation is being well supported but to accomplish its task needs further support and on an annual basis.

NEW OFFICERS

Edward J. McCormick of Toledo, Ohio, a member of the Board of Trustees for the past five years, is the new president-elect of the AMA. The defeated candidate for this office was F. F. Borzell of Philadelphia, retiring speaker of the House. Leo J. Schiff of Plattsburgh, New York, is the new vice-president. James R. Reuling of Bayside, N. Y., was elected speaker of the House and E. Vincent Askey of Los Angeles, vice-speaker.

TESTIMONIAL DINNER TO DR. LAWRENCE

Just prior to the official opening of the AMA session a testimonal dinner was tendered Joseph S. Lawrence who is completing his service as head of the AMA Washington Office. Dr. Lawrence was the first incumbent of this position, taking it on just eight years ago. He has been most successful in furnishing information to members of Congress and in keeping the medical profession informed of developments through his Washington bulletins.

There were many other social events during the busy week. Schering Corporation, Armour Laboratories, Searle, Philip Morris and other friendly corporations provided entertainment of varying kinds. Tours of the AMA headquarters building were conducted daily. Across the nation television programs were beamed from Navy Pier and from Wesley Memorial Hospital. A golf tournament was held as usual—no prize winners from Connecticut. Medical school alumni associations met. The Committee on Arrangements and the Committee on Scientific Assembly deserve a big hand. It was a great show!

IN FOREIGN LANDS

In Recent Crucial Elections

90% of Belgians √ VOTED

89% of Italians √ VOTED

82% of Englishmen √ VOTED

70% of Japanese √ VOTED

BUT IN THE U. S. A.

51% of Americans Voted in the Last Presidential Election!

LET'S BE 100% AMERICANS!

LET'S *REGISTER*

and

LET'S VOTE!

NEWS FROM WASHINGTON

Social Security Bill Defeated

HR7800, a bill to amend Title II of the Social Security Act to increase old-age and survivors insurance benefits, to preserve insurance rights of permanently and totally disabled individuals, and to increase the amount of earnings permitted without loss of benefits, was defeated during May. Defeat came after members learned the bill contained a section the AMA opposed as socialized medicine. Other sections of the bill, to which objection was not raised, would increase O.A.S.I. monthly pension benefits $5, increase allowable outside earnings of beneficiaries from $50 to $70 per month and give credit for time spent in military service.

Capitol observers and some Congress members are saying, but not for quotation, that AMA's spectacularly successful role in helping bring about defeat of HR7800 on House floor may boomerang. They acknowledge that AMA confined its opposition to this social security bill to those provisions which it claimed conferred too much authority on FSA Administrator Oscar R. Ewing. AMA President John Cline stated publicly that HR7800 as such is not the target, that opposition is limited to bill's "socialized medicine" sections. Nevertheless, the measure that would have benefitted some 5 million enfranchised elderly people and widows was defeated and political capital undoubtedly will be made of that fact—with AMA's role enthusiastically described—this fall.

If a "cleaned up" HR7800 is submitted and enacted, or if the less controversial HR7922 introduced as a substitute Tuesday by Rep. Daniel A. Reed (R—N. Y.) is approved by Congress, then danger of an AMA flareback would be lessened. However, House Ways and Means Committee is showing no sign of haste in bringing out either Reed's bill or a revamped version of HR7800, which indicates that a strategic bottling-up may be intended for political embarrassment of the Republicans—and AMA.

Addressing a meeting of Veterans Administration voluntary workers, President Truman placed blame for defeat of H7800 squarely on shoulders of AMA—"that great organization which hates the Administration worse than it hates the devil." He went on: "There are a lot of people in Congress who jump when the American Medical Association cracks the whip. And there are a lot of others who roll over and play dead when anybody yells 'socialized medicine.' "

On May 20 Mr. Reed of New York introduced HR7922, a bill to amend Title II of the Social Security Act to increase old age and survivors insurance benefits, to increase the amount of earnings permitted without loss of benefits, and for other purposes. This bill is identical with HR7800 except (1) the disability section which the AMA objected to is omitted, and (2) the sum of $100 per month instead of $70 provided by HR7800 could be earned by covered persons who have reached retirement age without jeopardizing their monthly social security benefits. It has been referred to the Committee on Ways and Means.

On June 17 this amended bill passed the House in spite of the fact that the AMA House of Delegates labelled it dangerous.

New Bills

HR7619—Alcoholics and Narcotics Addicts. By Mr. Ramsay, of West Virginia, April 28. To promote the general welfare by organizing a Bureau of Clinics for the treatment of chronic alcoholics and narcotics addicts. Referred to the Committee on Interstate and Foreign Commerce.

Comment: Would establish a Bureau of Clinics, as an independent office, in charge of a director to be named by the President and confirmed by the Senate. The director would be required to have at least 20 years' experience in cure and rehabilitation of chronic alcoholics and drug addicts and be trained in the medical sciences. The Bureau would establish, maintain, and operate a system of farms for treatment and rehabilitation of chronic alcoholics and drug addicts. Medical personnel would be permanently transferred from the Public Health Service to the Bureau. Other functions would include assisting the state and private agencies to establish similar farms, to train and educate personnel in

approved methods of treatment, cure, and rehabilitation of alcoholics and drug addicts, and to utilize the facilities of the U. S. Employment Service in finding suitable employment for those rehabilitated.

Actions

S1140—To create a Department of Health with cabinet status. A subcommmittee of the Senate Committee on Government Operations last week decided to abandon a bill providing for the establishment of a Department of Health. The subcommittee which has been assigned the preliminary consideration of the measure instead recommended a substitute measure (draft of which has not been released to the public) calling for the creation of a 10-member Federal Board of Hospitalization. Membership would consist of 4 from private life and 6 from the following federal agencies: (1) Department of Defense, (2) Department of Interior, (3) Veterans Administration, (4) Bureau of the Budget, (5) Public Health Service, and (6) General Services Administration. The Board would strongly influence questions of need, location and types of construction of new federal hospital facilities, and the problem of bed allocation among federal agencies in the interest of efficiency and economy. This idea has been advocated by the American Medical Association repeatedly.

S2731—Transfer of hospitals between Department of Defense and Veterans Administration. This bill was passed by the Senate on the Unanimous Consent Calendar on May 1 and was sent to the House of Representatives.

S3019—Extension of special military pay for physicians and dentists. The Senate Armed Services Committee favorably reported this bill May 1. It was called on the Unanimous Consent Calendar May 12 and after objection was passed over.

S3066—Defense housing and community facilities and services. The Senate Banking and Currency Committee May 16 favorably reported this bill with several amendments. One feature of the bill being followed with interest by the medical profession was an increase in authorization of federal funds from 60 million to 160 million dollars for assisting local communities in providing community facilities, including the construction and maintenance of hospitals and other places for the care of the sick. The committee reduced the 160 million dollar proposal to 100 million. This amount would cover expenditures from the bill's passage last year until June 1953. Congress has already appropriated, of the original 60 million authorization, the sum of 15½ million and a further appropriation of 14¼ million is pending.

S2552—To authorize the appointment of qualified women as physicians and specialists in the medical service of the Armed Forces. This bill was passed by the House May 19 with an amendment. The amendment was directed to a section of the Medical Office Procurement Act of 1947 and would permit the armed services to commission osteopaths in the Medical Corps.

S3015—Special pay for physicians and dentists in the Armed Forces. The Senate June 2 passed this bill after debating two modifying amendments. The amendments, offered by Senator Douglas of Illinois, would have: (1) reduced the $100 monthly special pay to $5; and (2) prevented a physician or dentist from receiving special $100 monthly pay and flight bonus at the same time. The first amendment was defeated by vote 50-4, and the second by an unrecorded vote.

Two bills identical with S3019 have been introduced in the House of Representatives—they are HR7976 (Rivers) and HR7995 (Vinson). With an anticipated adjournment in early July, there is some danger that the House may not act on this legislation. If the House does not act, physicians and dentists entering the military service after September 1, 1952, will not rceeive the special pay.

The pending bills provide for an extension of special pay until July 1, 1953. On the same date the Doctor Draft Act is scheduled to expire and the entire question of draft and pay of physicians and dentists would have to be taken up in Congress to effect an extension of the present law.

President Truman has signed the bill increasing compensation and pension payments for non service and service connected disabilities of veterans. Under the new law, non service connected pensions will go up a flat $3 per month, while veterans with service connected disabilities rated at 50 per cent or over will receive a 15 per cent increase in compensation and those rated less than 50 per cent, a 5 per cent increase. Mr. Truman asked for a study of veterans' benefits "and their relationships with our

social insurance and other general welfare programs."

Hearings

HR5426—To reorganize the reserve components of the Armed Forces. Public hearings were held by a subcommittee of the Senate Armed Services Committee beginning May 26, and concluded May 29. The American Medical Association submitted a statement urging: (1) that medical students be deferred from the draft and reserve service through the entire period of education, including internship and residency training; and (2) that a civilian board have authority to determine medical and allied health personnel military requirements to insure the proper distribution of medical and other health reserves between civilian and military needs. Practically all of the witnesses except the National Guard groups favored passage of the bill. Witnesses pointed out that the reserve components of the future would be made up of many more persons from the enlisted levels than heretofore due to the new selective service law which requires draftees to remain in a reserve status for six years following a two year tour of duty. In the past the proportion of officers to enlisted men has been much larger than it will be in the future.

Medicine, Dentistry and Law Support Tax Exemption Bill

One of the most powerful of House committees has taken under study a proposal solidly supported by the professions—amendment of the revenue laws to give self employed a measure of income tax relief while establishing voluntary pension funds. At an all-day public hearing conducted recently by Ways and Means Committee, a score of witnesses urged passage of Reed-Keogh bill, which would accomplish that end. Among them were Dr. David B. Allman, trustee, and Frank G. Dickinson, economist, representing American Medical Association, and Dr. Paul E. Jones, testifying in behalf of American Dental Association. Also, a statement supporting the bi-partisan plan was filed by American Osteopathic Association.

National organizations representing farmers, lawyers, accountants, engineers, authors, radio and television performers and other self employed citizens spoke up for Reed-Keogh. Spokesman for the steering committee that has been developing the plan for several years was Leslie M. Rapp, New York attorney.

TECHNICAL CHANGES URGED

By his own admission, Frank Dickinson's testimony marked his first appearance before a Congressional committee. He carried on, nevertheless, like a seasoned trouper, presenting ear-catching arguments and proposing technical changes in a manner that held the committee's attention. (Dr. Allman's chore was simply to review briefly AMA's efforts since 1948 to promote this type of legislation and then introduce the director of its Bureau of Medical Economic Research). Two suggested modifications were emphasized by Dickinson: Provision for a lifetime limitation of $150,000 on total amount excludable from taxable income and a past service credit provision, both of which are intended to prevent the plan from being too generous to the young at the expense of the old.

"The Treasury Department should have no real fear of losing a lot of revenue in 1953 if this bill is enacted in this session of Congress," he stated. ". . . I predict that the Congress 5 to 10 years after this measure is passed will be searching for ways to liberalize rather than to restrict the tax deferment encouragement to pensions which this bill provides."

LIMITED EARNING YEARS CITED

Dr. Jones, a member of ADA's Council on Legislation, stressed that dentistry—like medicine—calls for many years of professional preparation and then there are more years of building up to the peak earning period. This period, he said, is relatively short, too short to enable the practitioner to set up an ample retirement plan unless a form of income tax deferment is made available. "No one provides and contributes to a pension fund for him," said Dr. Jones. "No friendly law guarantees him minimum income in the event his patients fail to patronize him as is provided for the farmer whose market is depressed. There is no cushion akin to unemployment benefits for the dentist to fall back upon should his business fail."

RECAPTURE OF REVENUE LOSS

He and other witnesses pointed out that much, and perhaps all, of the immediate losses sustained by Treasury will be recaptured in later years when pension payments become subject to taxation. The situation is comparable to that presented by Section

165 of Internal Revenue Code, which extends tax deferral to salaried workers. Even if every dentist took advantage of Reed-Keogh plan, revenue loss would be comparatively low, $13 million a year for first few years, according to ADA estimate.

Department of Health Dropped in Favor of a Hospitals Board

Senate's government reorganization subcommittee has decided definitely to reject idea of establishing a Department of Health in President's Cabinet. Within a few days it will come up with an alternate plan to set up a strong Federal Board of Hospitalization. A distinctive feature of the bill, whose enactment the subcommittee will recommend, is that it provides for public representation on a board that would swing considerable weight on planning, location, construction and staffing of all Federal hospitals, military and civilian. American Legion, foremost opponent of Department of Health, is on record in favor of a hospitalization board but whether this version proves too strong for its taste remains to be seen.

The plan is a compromise that substitutes a coordination board for the more drastic consolidation of Federal medical and hospital activities. If enacted, it would give a partial victory to Citizens Committee for the Hoover Report—and its affiliated National Doctors Committee—and also satisfy Legion and AMA. At least that is thinking of O'Conor subcommittee, which is expected to indorse and transmit new bill soon to parent Senate Committee on Government Operations.

Medical Care Costs Up 2.2 per cent in First Quarter, Physicians' Fees 1.9 per cent

Reflecting first of year changes, hospital costs in large U. S. cities had risen 12.6 per cent in March compared with last December, a survey of the federal Bureau of Labor Statistics shows. A breakdown of costs showed that while costs of all medical care, including drugs, had risen 2.2 per cent, physicians' fees had gone up 1.9 per cent in the 3 month period. Other increases included: Blue Cross premiums, 2 per cent; optometrists' fees, 0.6 per cent; prescription drugs, 0.4 per cent and dentists' fees, 0.3 per cent. The Labor Department agency also reported that in March all miscellaneous goods and services (which include medical care) had risen 1.6 per cent above December.

Bugher to Succeed Warren As AEC Medical Director

Atomic Energy Commission last week accepted resignation of Dr. Shields Warren as director of biology-medicine division and announced appointment of Dr. John C. Bugher as his successor, effective June 30. Latter has been deputy director since February, 1951, when he left Rockefeller Foundation's International Health Division. Dr. Warren has been division head since its establishment in 1947, although he continued his service as pathologist at New England Deaconess Hospital, Boston, on a part time basis. In his letter accepting the resignation, General Manager M. W. Boyer of AEC hailed Dr. Warren as "one of the architects of the atomic energy program" and paid high tribute to the division's record in promoting safety in production plants and developing research in atomic medicine and biology.

RECORD OF ACCOMPLISHMENT

Since inception of biology and medicine program in October, 1947, there have been no radiation deaths at any of the national laboratories. A research network has been achieved in which numerous hospitals and universities are participating. Definite leads have been obtained on treatment of radiation injury and progress is being made toward solution of genetic problems. In the opinion of Dr. Warren, one of the most important advances is the impetus given to postgraduate scientific training by AEC's fellowship program. In this regard, announcement was made last week of a new one year fellowship training program for industrial hygienists. It will begin this fall, with candidates to be selected by a committee whose members include Drs. Philip Drinker and Theodore Hatch, of Harvard and University of Pittsburgh Schools of Public Health, respectively, and Dr. Warren. Information and application blanks will be supplied by Merril Eisenbud, New York Operations Office, U. S. Atomic Energy Commission, P. O. Box 30, Ansonia Station, New York 23, N. Y.

Chloramphenicol Warnings Sent Out to Army Doctors

Almost simultaneously with issuance of caution statement by Parke, Davis and Food and Drug Administration, office of Army Surgeon General has dispatched notice to all medical facilities to exercise extreme care in use of chloramphenicol (Chloro-

mycetin). Army doctors are advised (1) to use the antibiotic only when dictated by strong indications, and (2) to terminate administration as soon as possible, meantime frequent blood cell counts. Situation was brought about by reports to FDA's antibiotic division of some 40 cases of aplastic anemia, some of them fatal, which followed administration of chloramphenicol.

Dr. Henry Welch, chief of antibiotic division, pointed out that evidence clearly fixing culpability on chloramphenicol is still lacking, many of the two score affected patients having been on other drugs as well. He observed further that followup studies conducted at Gallinger and Children's Hospitals in this city have disclosed no resultant anemias, also that the 40 cases reported nationally represent a statistically insignificant ratio of 1/400,000.

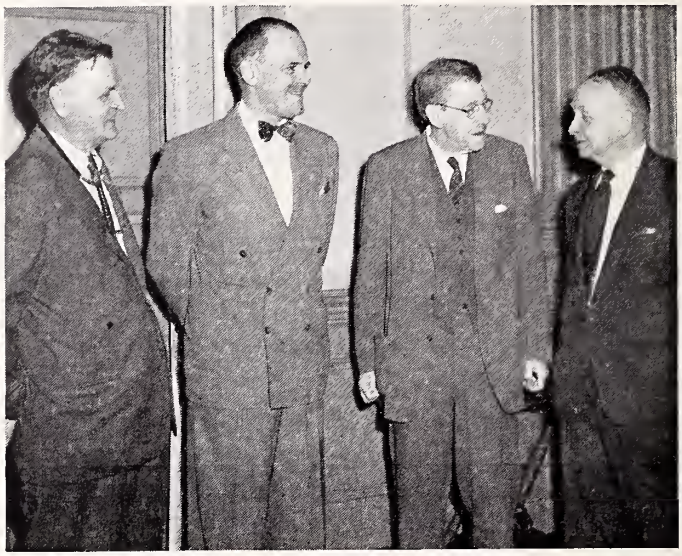
Provisional Clearance Given Isoniazid for TB Treatment

In releasing isonicotinic acid hydrazide (isoniazid) into commercial channels last week, Food and Drug Administration specified that the drug—under whatever trade name it may be distributed—shall state on label that it is "for use in the treatment of streptomycin resistant tuberculosis, under close supervision of a physician." FDA emphasized that it is not approving or indorsing isoniazid but simply holding it to be safe when used in conformity with labeling. Commenting on Federal release, Managing Director James E. Perkins of National Tuberculosis Association said new drug is a significant step forward but warned against any concept that it offers complete solution of tuberculosis problem.

Dr. Winternitz Heads Committee

The new executive committee of the National Research Council's medical sciences division for 1952-1953 is to be headed by Milton C. Winternitz of Washington, D. C., a member of the New Haven County Medical Association. On this committee also is Chester S. Keefer of Boston.

Cancer Society Presents 1952 Award to Dr. Charles L. Larkin



Principals at the Connecticut State Medical Society's annual dinner in Hartford, Wednesday, April 30, at which Dr. Charles L. Larkin, left, of Middlebury, received the American Cancer Society award, presented annually by the Connecticut Cancer Society. The presentation, consisting of an engraved citation and a bronze medal, honored Dr. Larkin's significant contribution to the State's cancer-control program, as president of the first voluntary organization in Connecticut, formed to counter cancer. Founded in 1940, the group was known as the Connecticut State Committee of the American Society for the Control of Cancer, Inc., and was the official forerunner of the Connecticut Cancer Society. Shown above with Dr. Larkin from left to right are: Governor John Lodge, Dr. A. Nowell Creadick of Newington and Dr. Samuel C. Harvey of New Haven. The latter two are former recipients of the award. Dr. Alfred L. Burgdorf of Hartford, president of the state cancer group, made the presentation.

Nobody's *too busy* to REGISTER

Nobody's *too busy to* VOTE!

DON'T NEGLECT YOUR PRACTICE IN CITIZENSHIP!

MORE THAN A MILLION

Emergency services sponsored by county and local medical associations are now available for more than a million Connecticut residents.

These emergency call systems radiate from twelve principal communities — Hartford, New Britain, Waterbury, Bridgeport, Norwalk, Stamford, Greenwich, Danbury, Torrington, Manchester, Norwich, Putnam — and similar systems are being planned in other localities.

Programs of this type demonstrate the strength of medical associations to act for the people — in terms easily understood by everyone.

Community Services
Build Good Will

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Medical Associations Develop Emergency Services for One Million Residents in Eighteen Months

Ninety per cent of the medical emergency network now serving more than a million Connecticut residents has been created by county and local medical associations in the past eighteen months, according to a recent survey.

Sponsored by the State Medical Society's Committee on Public Relations, the survey indicates that eight of the twelve association-sponsored emergency plans were started this year.

The most recent system was initiated by the Waterbury Medical Association in March. Other cities of more than 50,000 population that have formally organized emergency systems in operation include Hartford, New Britain, Bridgeport and Stamford. A special committee of the New Haven Medical Association is perfecting plans for an emergency system in that city and it is anticipated it will be ready for operation at an early date. Another study is being conducted in Middletown under auspices of the Central Medical Society and the Middlesex County Medical Association to modify an existing informal plan of emergency service.

Medium size and smaller communities where the new systems are operating comprise Torrington, Danbury, Greenwich, Norwalk, Manchester, Norwich and Putnam.

Approximately 600 calls per month are being received by the twelve systems throughout the State, the survey indicates. The number of physicians participating in emergency panels varies from ten in smaller communities to more than 40 in major cities, with rotation of membership at specified intervals.

The oldest system in point of 24 hour operation was started by the Bridgeport Medical Association in June, 1949. In other communities part-time emergency and information services were sponsored by medical groups for several years prior to that date and these have been modified to meet the requirements of complete community service.

In addition to the new emergency systems there also are a number of local arrangements between physicians and hospitals, but in most instances these are not directly sponsored and supervised by medical associations. The three principal requirements of the new type emergency plans are (1) that the system be sponsored and directed by a medical group or association, (2) that emergency services be available at all times and (3) that an organized panel of physicians be available for emergency calls.

Emergency Services Featured in Telephone Publication

When Connecticut residents open their July telephone bills, they will find an interesting account of emergency medical service systems sponsored by county and local medical associations.

The story is contained in the current issue of *Telephone News*, published monthly by the Southern New England Telephone Company for its 600,000 Connecticut subscribers.

The article points out the importance of efficient telephone service for the successful operation of emergency call systems and was prepared under the direction of Geary E. Griffith, editor of the publication.

Association Leaders Advance Voluntary Health Insurance

Medical leaders in several sections of the State are cooperating in a program to advance voluntary health insurance.

Planned as a follow-up of the third birthday observance of Connnecticut Medical Service, May 15, the program is designed for press and radio use.

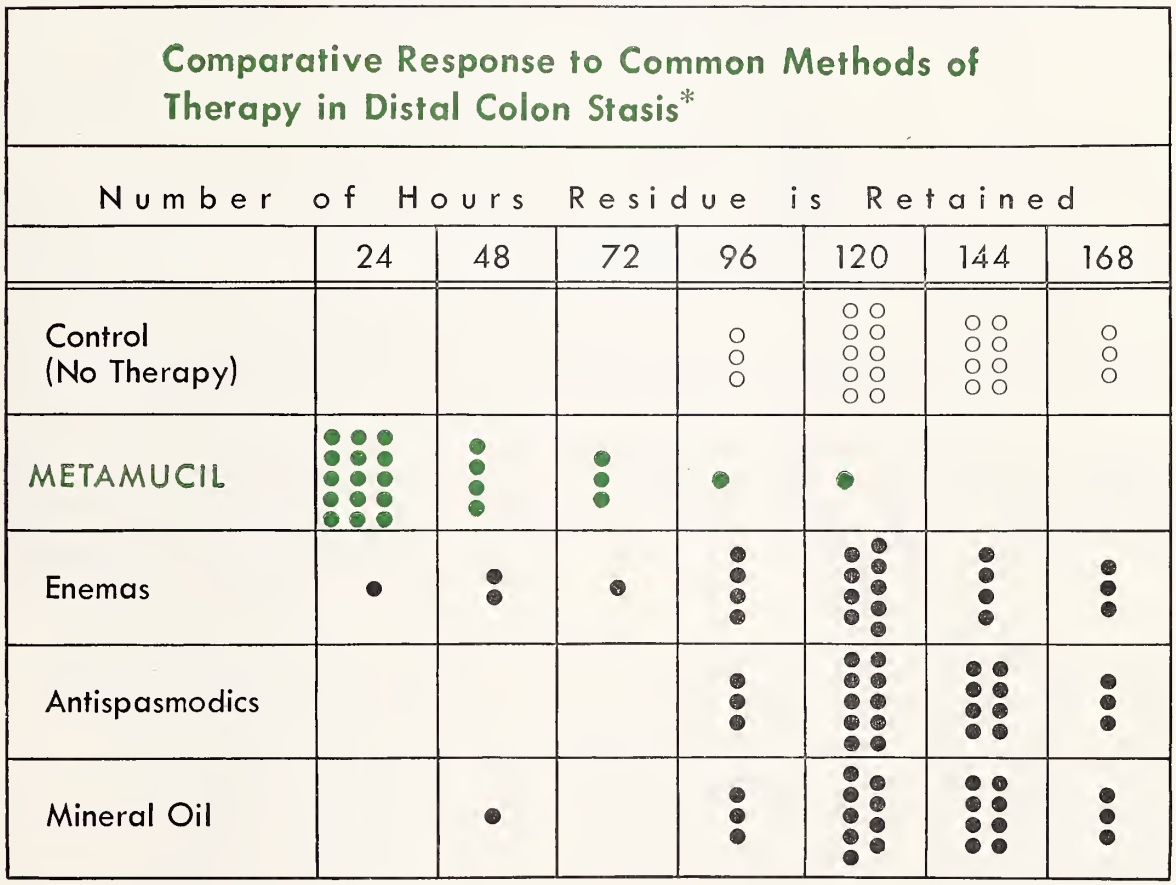
Five radio interviews were scheduled during June

METAMUCIL®

Effective in Distal Colon Stasis*

"A roentgenographic evaluation of the common methods of therapy . . . demonstrated that . . . a mucilloid substance (Metamucil) has been most effective in the most prevalent [type of colonic stasis], distal colon stasis. . . . Enemas gave good results in rectal stasis only. Mineral oil had very little effect. Antispasmodics and sedatives had no efficacy. . . . It was found that the use of habit forming cathartics may be avoided in most instances."*

Comparative Response to Common Methods of Therapy in Distal Colon Stasis*



ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

and others are plannned for broadcast within the next two weeks. Physicians who participated in the June programs were Thomas J. Danaher, Torrington, president of the Litchfield County Medical Association; Paul W. Tisher, New Britain, president of the New Britain Medical Society; Thomas M. Feeney, Hartford, secretary of the Hartford County Medical Association; William H. Curley, Jr., Bridgeport, member of the Professional Policy Committee, CMS; and William H. Horton, CMS general manager and medical director.

Newspaper announcements concerning the progress of CMS were released by the presidents and secretaries of medical associations in Hartford, New Haven and Fairfield Counties as another feature of the June program. Other releases are planned for future use.

Medical Film to be Released Soon

"Your Doctor," a movie short produced by RKO-Pathe in cooperation with the American Medical Association, soon will be shown in 3,500 theaters throughout the country with a potential audience of 30 million persons.

A premier showing of the film was held in Chicago last month in connection with the Association's annual convention there. Detailed information concerning the production will be sent in advance to all state and county medical associations.

Medical Writing

In an article, "On Writing to be Read," which appeared in *The Lancet* (London) for August 25, 1951, Dr. J. W. Howie, head of the Pathology Division of the Rowett Research Institute, gives some sound advice to writers. He writes:

"Doctors and scientists usually seem to dislike writing about their work: 'I hate the writing-up,' they often say. Perhaps it is the 'up' that does the harm. If authors were content to write instead of writing-up, many mistakes might be avoided. Writing-up suggests that the author feels the need to do something beyond communicating his facts and thoughts. Often it seems as if authors work hard to introduce much that a good editor will remove, because of his duty to see that readers are not bored or bewildered.

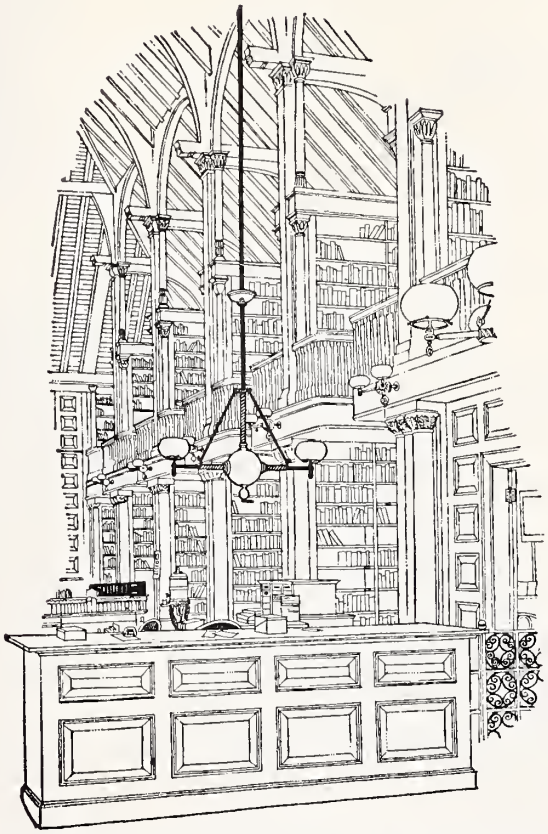
"Authors engaged in writing-up often seem to think that they must make a powerful impression. Some of this may arise from deliberate or unconscious imitation of works which are justly regarded as classics. Such works are classics because they contain valuable new facts and ideas, not because they have been written in the grand manner, or perhaps directed with particular energy against someone whose views the author wished to contradict. Incidental attributes of this kind do not prevent papers with new and good information from becoming classics, but they are not the things that confer lasting value. The only 'incidental' which has a truly classic quality is simplicity."

According to Dr. Howie, "A scientific paper should be as precise as a legal document, but it should also be as readable as a good short story."

"Scientific writers have much to learn from professional journalists about the needs of readers. Discussing an article which he had prepared for an evening paper, a friend of mine, an experienced journalist, explained the situation as he saw it. The article, my friend assumed, would possibly come to the reader's notice as he sat by the fireside, taking off his boots with one hand, balancing the paper against the side of his chair with the other, and all the time increasingly interested in the odours from the cooking of his evening meal. A severe test for the article! My friend stressed how important the title became under these conditions: it might have to compete with bacon and egg. The title alone would be in big enough type to catch the wandering eye; therefore it must establish interest. 'Why tall men marry short girls' would therefore be a better title than 'Disparity of vertical dimension as a contributory factor in matrimonial inclination.' Although readers of scientific periodicals are not surrounded by the same competing interests as readers of evening papers, their attention must be caught and their interest held by similar, if perhaps less obvious, methods. The title of a scientific article deserves the author's careful thought; it should be freed of dull, inoperative words and should accurately indicate what interesting news the reader may expect. The first paragraph is equally important. My journalist friend assured me that having written an arresting title and a bright opening paragraph he felt sure of holding his reader. It is an excellent thing if the first paragraph of a scientific article tells what was done and why, and what the results were. This has long been recognized as essential in a summary, and it perhaps explains why some journals publish the sum-

(Continued on page 566)

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.



Interior of the
Howard Memorial Library,
New Orleans, La.

From among all antibiotics Otolaryngologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin appears rapidly in the tissues of the ear, nose and accessory sinuses, and in the cerebrospinal fluid.

Aureomycin, when given intravenously, attains maximum concentrations in the plasma within 5 minutes.

Aureomycin exhibits little tendency to favor the development of bacterial resistance.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions frequently seen by otolaryngologists:

Laryngeal Infections • Otitis Externa • Otitis Media
Mastoiditis • Pharyngitis • Sinusitis • Tonsillitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

176 Hospital Internships Offered by Navy for 1953

Navy's Bureau of Medicine and Surgery announces 176 internships in naval hospitals will be set up for medical graduates of 1953. Army and Air Force programs for next year are not quite complete but likelihood is that they will offer same number as 1952, respectively, 150 and 60 internships. All applications will be processed in accordance with National Interassociation Committee system of appointments. Students who are interested in a naval internship are invited to communicate with regional offices of naval officer procurement or write for information to Surgeon General, Navy Department, Washington 25, D. C.

Latest Figures Disclosed on Doctor-Draft Registrants

Compilation made at Selective Service headquarters, based on figures supplied by the states draft boards, includes following information: As of April 30, physicians in Priority I who had been classified 1-A for military service totalled 1,119; in Priority II, 530. Corresponding figures for March 31 were 1,101 and 535, revealing slight change in these categories. In greater contrast was the dental picture, the pool of 1-A's in Priority I having dropped from 537 to 339 in 30 days. Actually the number is much lower than 339, since there is considerable lag in notification of draft boards that special registrants have received military commissions. Priority I pool of 1-A dentists is expected to be used up in this month's callup of 175 registrants and Priority II will be tapped for July call.

Maj. Gen. Lewis B. Hershey, Selective Service Director, has requested all local boards to mail classification questionnaires to all dentists registered in Priority III—a large group composed of non veterans of World War II—whose dates of birth are on or after May 1, 1917. Since the Priority II dental pool of 1-A's totaled only 128 as of end of April, it is apparent that III's may be summoned by Selective Service in not too distant future. One official estimates that 2,500 physicians and 1,300 dentists will complete obligated military duty and apply for discharge during second half of 1952.

AMA Asks Medical Student Deferment From Draft and Reserve Service

The American Medical Association, in a statement filed with the Senate Armed Services Committee, requests that the reserve reorganization bill (HR5426) include a section deferring medical students from the draft and reserve service until they complete their medical training. Such deferment, AMA said, would apply also in the event Congress puts a universal military training program into operation.

The AMA also asked the committee to insure that (a) no undue advantage accrue to armed forces hospitals by allowing internships and residency service in these installations to count against total reserve obligation, and (2) authority be vested in a national civilian board to insure proper distribution of medical and other health reserves between civilian and military needs under a UMT program. The reserve act, which has passed the house, reorganizes the reserve components of the three military services.

Military Personnel and U. S. Public Health Service Doctors Receive Pay Increase

Completion of Congressional action means a pay increase, retroactive to May 1, for all military personnel (including reserves and retired) and commissioned members of the U. S. Public Health Service. President Truman has signed the bill and the increases will appear on paychecks for May. The conference report was approved unanimously by both House and Senate (333 to 0 in House, also unanimously in Senate, but only six Senators present.) Base pay will be increased 4 per cent and housing and subsistence allowance 14 per cent. It is estimated the annual cost will be $484 million.



"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

CHLOR-*TRIMETON*
maleate

1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

Schering CORPORATION
BLOOMFIELD, NEW JERSEY

CHLOR-*TRIMETON*

SCHERING

FROM OUR EXCHANGES

"The Dangers of Obscuring Serious Disease by Early Chemotherapeutic Treatment of Mild Symptoms" by Harrell may be found in the *North Carolina Medical Journal*, 12.9. If the indiscriminate use of chemotherapeutic agents for the treatment of symptoms is continued, the diagnoses will be obscured and necessary measures for the proper care of patients often will be delayed until serious disease has developed. Careful preliminary studies should be done before a therapeutic trial of chemotherapy is considered.

* * * *

C. D. Selby of Ann Arbor, Michigan discusses "Physical Examination in Industry as a Cancer, Case-finding Procedure" in the *Rhode Island Medical Journal*, 34.11. Dr. Selby believes the employer-physician relationship gives the industrial physician the opportunity to counsel with a large group of employees to an extent enjoyed by few physicians outside of industrial practice. Through the records which are kept it quickly becomes evident that certain employees are suffering from conditions which require close study and perhaps active treatment by their family physicians. The author believes that industry's contribution through medical routine is good but perhaps not sufficient and that possibly a plan for tumor detection integrated with routine industrial medical services may be in order. Industrial medicine if not equipped to make all kinds of examinations on both male and female employees in certain instances should be content to act as feeders to the family doctors who may be participating in cancer detection. Industrial medicine departments can be helpful in the promotion of cancer control through health education. Industrial medical examinations being highly specialized, can be used only for the early detection of cancer through incidental findings and from by-products arising during the procedure. Day to day contacts between plant physician and employees often bring out leads which direct the physician's attention to the possibilities of early detection of malignancies.

* * * *

J. Ernest Ayre *(Jour. of Florida Med. Assoc.*, 38.7) discusses "The Role of Cancer Cytology in Medical Practice." The Dade County Medical Society (Florida) is sponsoring a program that offers a cytological diagnostic service to the physicians of the area.

A cytological examination of the sputum offers the earliest form of diagnosis of pulmonary cancer. The patient simply spits into a bottle of alcohol. It is advised that three separate specimens collected on successive days are needed for an adequate examination.

Cell scrapings from the cervix offers almost complete control of cervical and uterine cancer. It is hoped that cytological centers screening for cancer will soon parallel the screening for tuberculosis, which has been a success in the various antituberculosis programs.

The plan in Dade County is not only to offer a diagnostic cytological service but to continue research in the new field of diagnosis. It is also desired to institute a program in which doctors can be trained to become cytologists and where technicians who desire to master the techniques of cytologic screening can study.

* * * *

An interesting recent addition to medical literature is the journal, *Harofe Haivri*. As the name suggests it is a Hebrew medical journal. It is divided about equally between articles printed in English and in Hebrew. Its main interest at the moment for most of us is the picture it gives of the medical situation in the near east.

* * * *

F. S. Crockett *(W. Va. Med. Jour.*, 48.1) in a discussion of rural health problems asks "Why Wait—Let's Do It Ourselves." He sensibly points out that the promotion of health, rural or elsewhere, is a long term effort. Health promotion programs are supported in the degree that the people individually and collectively are convinced of their real value.

Dr. Crockett is convinced that there has been too much effort to do things for people. The sound program in his opinion is that one where the people are encouraged to do for themselves and to create for themselves the health protection that medical science has to offer today for the prevention of

disease and the promotion of health. An awakened citizenry accepts responsibility in many other fields aside from those of health. Better roads, improved telephone service, attention to school sanitation, the control of animal disease and water supply are among the side benefits that result in a community interest in health.

Dr. Crockett points out that "any community, any family, any person, can have that degree of health and happiness for which they are willing to work and to obtain for themselves."

* * * *

Edward F. Lewison et al *(N. E. Jour. Med.*, 246.1) in an article entitled "Sex Hormones in Breast Cancer" points out the fact that such hormones are not a "cure," but that they do offer a profound and gratifying benefit to patients beyond the scope of surgery or radiotherapy. With their help the "cancer may yet be palliated, if indeed not conquered."

* * * *

In the *Delaware State Medical Journal* (23.11) there appears a superior review of the whole subject of "The Office Management of Diabetes" by Perry S. MacNeal. Symptoms, diagnosis, treatment with insulin, and dietetic control are covered in a complete and comprehensive manner. A point of emphasis in the paper is the necessity for discovering the unknown diabetic early in his disease. It is desirable to direct the attention of the practicing physician to the value of postprandial blood sugar and urine examination.

It is an article that is simply and plainly written; and is in its entirety filled with a common sense approach to its subject.

* * * *

Intussusception (Arthur W. Ide, *Jour. Lancet*, 71.12) is described as the most frequent cause of intestinal obstruction in infants. However, when the picture of obstruction is present the process is already far advanced. The classical picture of intussusception in infancy consists of colic, vomiting, palpable mass and melena. Most of these features are commonly present but are subject to a considerable variation. The duration of the symptoms is an important factor in the mortality rate of intussusception. Early diagnosis depends on finding two or more of the classical symptoms, namely pain, vomiting, melena and sudden onset.

The treatment in this country is usually surgical. However, good results have been achieved in this country on occasions by rectal irrigations. This last method seems to be preferred in Australia and in Scandinavian countries. When rectal irrigations are used it is wisdom to be prepared to turn to surgery in case there is a failure to reduce the intussusception.

* * * *

E. Janney Smith reviews (*Jour. Mich. State Med. Soc.*, 50.12) 920 cases of myocardial infarction. The ratio according to sex in his cases was 4.4 males to one female. Women on the average were somewhat older at the time of onset than the men in the series.

The mortality rate was found to be influenced significantly by the sex of the patient, the age of onset, the site of the myocardial infarction, the degree of leucocytosis, the presence of thromboembolic complications, the presence of cardiac arrhythmias, the presence of congestive heart failure, and the history of previous myocardial infarction.

Hypertension, angina pectoris, diabetes mellitus and obesity seem to have no influence on the mortality rate though all were frequently encountered in this group of cases.

Anticoagulant therapy had a distinctly favorable influence on the mortality rate. Dicumarol alone seemed as effective as Dicumarol plus initial Heparin in preventing thromboembolic episodes. Digitalis seemed to be beneficial in treating congestive heart failure ;certainly no unfavorable effect was evident. Quinidine in adequate doses influenced favorably the outcome of a few cases of ventricular tachycardia. Neither digitalis nor quinidine appeared to be beneficial in the conversion of auricular fibrillation to sinus rhythm. A high incidence of premonitory pain occurring a few days to four weeks prior to acute myocardial infarction was striking in the series of cases studied.

* * * *

"Silage Gas Poisoning" is described by Gerald A. Fostvedt *(Wisconsin Med. Jour.*, 50.11). Silo workers should be advised to make sure that the silo area is adequately ventilated prior to and during confinement to such an area. The atmosphere should be tested with a flame or by other suitable means before entering the silo (small animal will do). Artificial respiratory techniques should be known to people working around and inside silos. Such accidents are not common but they occur too often.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
First Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville



Sally Tracy (Mrs F. Erwin)

Connecticut medicine has been signally honored by the election of Sally Tracy (Mrs. F. Erwin) of Middletown as third vice-president of the Woman's Auxiliary of the American Medical Association. Mrs. Tracy only two months ago retired as president of the Connecticut Auxiliary. She served as Conference secretary at the Eighth Annual Conference of State Presidents, Presidents-elect and National Committee Chairman of the National Auxiliary at Chicago in November 1951.

State News

The 20th Annual Convention of the Woman's Auxiliary to the American Medical Association was held in Chicago, at the Conrad Hilton Hotel, June 9 to 13 inclusive.

The delegates appointed to represent Connecticut were as follows:

Presidential delegate: Mrs. Barnett Freedman, New Haven.

President-elect: Mrs. Dewey Katz, Hartford.

Also: Mrs. Stevens J. Martin, Hartford; Mrs. Royal Meyers, Litchfield; Mrs. F. Erwin Tracy, Middletown; Mrs. Winfield E. Wight, Litchfield.

MIDDLESEX COUNTY

The Red Cross Chapter in Middletown has enrolled interested members of the Auxiliary in a First Aid Class, embracing a period of eleven weeks. This program is being featured in connection with the Civilian Defense program.

The Annual Luncheon Meeting was held April 24 at Monte Green Inn, Middletown. There were 26 members present. The annual reports indicated that the Auxiliary has engaged in many successful activities this year.

Mrs. B. A. Roccopriore presented a film of her recent trip to Europe.

NEW HAVEN COUNTY

The Annual Luncheon of the Woman's Auxiliary to the New Haven County Medical Association was held May 8 at the Sanford Barn, Hamden.

Dr. Everett H. Rademacher, guest speaker, presented a talk entitled "The Doctor's Mental Health."

Mrs. Orvan Hess presided at the meeting.

NEW *5-mg. Tablets of* Cortone®

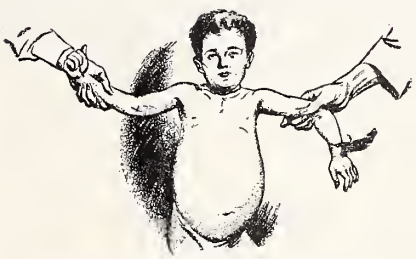
For accurate adjustment of Maintenance Dosage and for therapy in conditions responding to Low Dosage



RHEUMATOID ARTHRITIS



ADDISON'S DISEASE



ADRENOGENITAL SYNDROME



FOLLOWING BILATERAL ADRENALECTOMY

Advantages of 5-mg. Tablets

FLEXIBILITY—

Used alone or in conjunction with the 25-mg. tablets, the new 5-mg. tablets afford greater flexibility in adjusting dosage to the individual patient's requirements. Fluctuations in the natural course of rheumatoid arthritis may be better controlled.

ACCURACY—

Permit more accurate establishment of minimum maintenance doses, thus controlling symptoms more closely and further minimizing the incidence of undesirable physiologic effects.

ECONOMY—

Prevent waste of CORTONE by more exact correlation between requirement and dosage.

Literature on Request

Cortone*
ACETATE
(CORTISONE ACETATE, MERCK)

*CORTONE *is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone. This substance was first made available to the world by Merck research and production.*

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

SPECIAL NOTICES

COURSE IN POSTGRADUATE GASTROENTEROLOGY

The National Gastroenterological Association announces that its Fourth Annual Course in Postgraduate Gastroenterology will be given at the Hotel Statler in New York City on October 23, 24, 25, 1952.

As in past years the Course will again be under the direction and cochairmanship of Owen H. Wangensteen, professor of surgery of the University of Minnesota Medical School, who will serve as surgical coordinator and I. Snapper, director of medical education of The Mt. Sinai Hospital, New York, N. Y., who will serve as medical coordinator.

Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools in and around New York City whose presentations will cover: diseases of the mouth, diseases of the esophagus, diseases of the stomach, diseases of the pancreas, psychosomatic aspects of gastrointestinal disease, diseases of the liver and gallbladder, diseases of the pancreas and spleen, diseases of the colon and rectum from the medical as well as surgical aspects, and other miscellaneous subjects including pathology, physiology, radiology, gastroscopy, etc.

One complete session will be devoted to a Clinical Pathological Conference at the Mt. Sinai Hospital in New York City.

For further information and enrollment write to the National Gastroenterological Association, Department GSJ, 1819 Broadway, New York 23, N. Y.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1952 AWARD CONTEST

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1952. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in October of 1952.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving Certificates of Merit, in its Official Publication, *The Review of Gastroenterology.*

All entries for the 1952 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and must be received not later than September 1, 1952. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

NEW ENGLAND POSTGRADUATE ASSEMBLY

The 1952 session of the New England Postgraduate Assembly will be held at the Hotel Statler, Boston, October 28, 29 and 30.

MEDICAL WRITING

(Continued from page 558)

mary at the head of the article. This may offend some as inelegant and too frankly utilitarian; but it is realistic.

"Readers of scientific articles, however conscientious, have difficulty in reading all that they wish. However hard they try they will have to skim some articles very lightly, and this is one reason why the summary, tables, and illustrations must be clear and completely intelligible without the text. Writers who wish to have their work carefully read will do well to learn as much as they can both of the trade and the tricks of popular journalism. Naturally, opinions differ about the value of some of the articles offered in popular newspapers, but the men who publish these articles have much to teach scientists about methods of presentation and clear statement."

INCOME TAX DEDUCTION

(Continued from page 535)

It is difficult to understand why a professional should be penalized because knowledge is conveyed to him orally rather than by writing. In a number of similar situations outlays incurred to maintain a professional position have been regarded as ordinary and necessary business expenses. Such expenses in question are not induced for comfort, convenience, or other personal considerations but to maintain, preserve, and continue the petitioner's trade or business and should be deductible for federal income tax purposes.

WYDASE IN OFFICE PRACTICE

Part of a series on its everyday use

Wyeth®



Reduction of Simple Fractures

In the reduction of simple fractures, Wydase added to a local anesthetic solution*:

1. Hastens onset of anesthesia
2. Promotes wide diffusion of injected anesthetic
3. Reduces swelling, thus permitting snug-fitting cast

Supplied: Vials of 150 and 1500 turbidity-reducing (TR) units.

**150 TR units when added to 25 cc. of anesthetic usually suffices. See package circular.*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Lyophilized

WYDASE®

Hyaluronidase Wyeth

Wyeth Incorporated • Philadelphia 2, Pa.

NEWS
from County Associations

Fairfield

Robert J. Hansell formerly in the practice of ophthalmology in Greenwich, has joined the Medical Division of the E. I. duPont de Nemours Company of Wilmington, Delaware, and has closed his office in Greenwich. Dr. Hansell was a member of the Board of Trustees of the Fairfield County Medical Association for three years.

Andrew P. Owens, having completed his surgical training at the Boston City Hospital in Boston, has opened an office in Bridgeport for the practice of general surgery.

The first tournament of the Fairfield County Medical Golf Association was held at the New Canaan Country Club on the afternoon of May 28. Thirty-four members of the group were present. Competitive play began officially with the June meeting held at the Mill River Country Club in Stratford on June 25.

The annual outing of the Bridgeport Medical Association will be held on July 16, with the golfing tourney at the Mill River Country Club on July 2. The outing plans are being formulated by the able committee of Tom Tarasovic and Ned Trautman.

At the June meeting of the Bridgeport Medical Association held at the auditorium in St. Vincent's Hospital on June 3, the usual form of the meeting was deviated from in that this meeting was strictly for the purpose of concluding accumulated business. It was voted to change the place of meetings from the two hospitals to a more central place. The constitution and by-laws of the association are to be revised. William H. Curley, Jr., reported on the new changes in CMS providing for inhospital medical care and Dr. Curley asked for the cooperation of the members of the medical association. The Public Relations Committee of the association presented a report of progress and are to coordinate their activities with the public relations committee of the Fairfield County Medical Association. It was agreed by all at the meeting, which incidentally was the best attended in several years, that this type of meeting should be a must in years to come. Many "gripes" which had been asked for in the call of the meeting were aired and constructive suggestions were obtained for future activities of the association.

Members of the Fairfield County Medical Association are being canvassed to determine if there are a sufficient number who are members of Blue Cross to have a group membership and in that manner decrease the cost to the individual member. As with all such questionnaires, although it is known that a sufficient number are members of Blue Cross, up until a month from the time of the canvass the interest in the members has not produced the number required.

The semi-annual meeting of the Fairfield County Medical Association will be held at the Wee Burn Country Club in Darien on October 1.

Richard E. Caron of Fairfield has been appointed full time health officer for that town. Dr. Caron comes to Fairfield from Milwaukee where he was engaged in public health work.

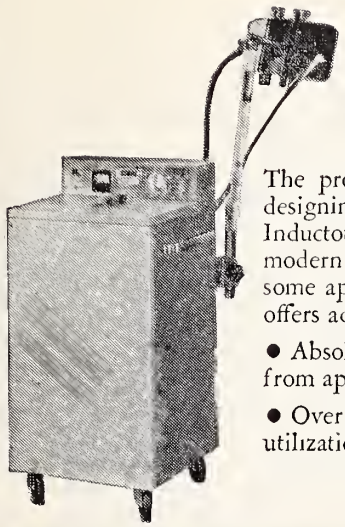
Hartford

In its May newsletter Hartford County warned its members that some doctors are being "solicited to buy stock in drug distributing concerns with the promise of big dividends and great capital gains." Pointing to Chapter I, Section 6 of the AMA code of ethics, the editorial said, ". . . the only thing to commend the plan of owning a part of a drug distributing business is that there might be some money in it."

Thomas M. Feeney, secretary of the County Association in his statement to the press just after an earlier disclosure that these unethical practices existed in Kings County, New York, said that such collaboration between doctors and drug houses in which doctors would recommend or prescribe the drugs of the company in which they held stock was a "questioned" violation of the AMA principles of ethics. He also pointed out that some of the products of one of the drug houses were "imitations of national brands" and were overpriced.

June 17 was the night set for Hartford County's first press-radio dinner. Invitations went out to all the dailies and radio stations in the county to participate in this meeting. The dinner was held at the Hartford Club.

Following through on the state's suggestion that HCMA endorse the Reed-Keogh bill and urge their



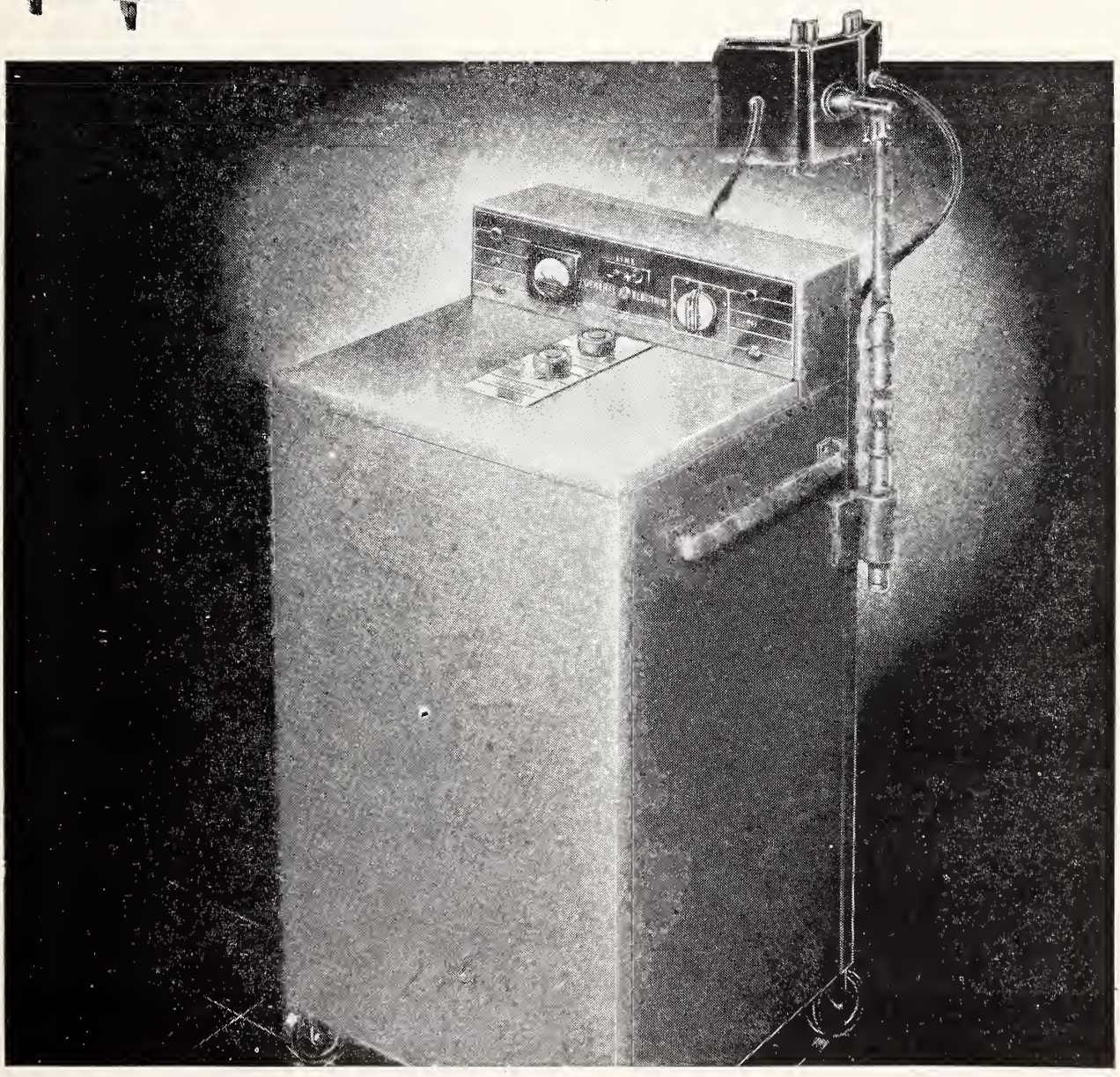
General Electric announces... a new, improved Inductotherm

The product of complete restyling and redesigning, General Electric's new Model F Inductotherm meets every requirement for modern diathermy technics. More than handsome appearance, this scientific development offers advanced features like these:

- Absolute crystal control limits variation from approved frequency to less than 0 05%.
- Over 200 watt output — for most efficient utilization of induction heating methods.
- Provision for three types of electrodes — contour, cable and air-spaced.
- Surgical facilities, now an integral part of the unit, for all medium and light technics.

Ask your GE x-ray representative for all the facts on the Model F, the Inductotherm apparatus that *fully* meets today's needs.

GENERAL ELECTRIC



Direct Factory Branch: **178 South Whitney Street, HARTFORD**

Congressmen and Senators to support the bill's passage, letters have been sent to Representatives Ribicoff and Sadlak, and Senators Benton and McMahon. With the exception of Benton, replies have indicated that they will help support the Reed-Keogh bill.

At the suggestion of and with the help of HCMA the Woman's Auxiliary has sent out letters to the wife of every doctor in the county urging them to write to their Congressmen about the Reed-Keogh bill.

CMS got a few radio plugs last month from county doctors. Thomas M. Feeney, a member of the professional policy staff of CMS, spoke for five minutes over radio station WONS on Memorial Day. Paul W. Tisher, president of the New Britain Medical Society, gave a five minute talk over station WHAY on June 10 on the growth and development of CMS.

HCMA unveiled its first poster at the New England Health Institute at Storrs, June 18, 19 and 20. The poster illustrated some of the activities of the county and was displayed with the Connecticut State Medical Society exhibit.

In line with Alfred Burgdorf's request of HCMA asking for the appointment of three physicians to work with him in setting up a predisaster medical civil defense plan, the county selected W. Holbrook Lowell, Jr., of Hartford and Charles Schechtman of New Britain. A third doctor will be named later.

HCMA last month asked its doctors to number the times any given prescription was to be filled. This action was taken at the request of the county pharmacists who suggested that prescriptions blanks be numbered. Furthermore, the Durham-Humphrey Act went into effect the last of April and this act prohibits the pharmacist selling many commonly used drugs unless he receives oral or written directions from the physician. Indicating whether the prescription is to be filled and refilled will avoid doctor-druggist telephone calls.

Stevens J. Martin, head of the anesthesiology department of St. Francis Hospital, Hartford, was honored recently by election to a vice-presidency in the New England Society of Anesthesiologists. He is the first Connecticut man to hold this post. Last month Dr. Martin also addressed Torrington Rotarians on "Anesthesia—Medicine's Indispensable Specialty."

On May 1, the staff of the New Britain Memorial Hospital elected the following officers: Sidney E. Eisenberg, re-elected president; Dwight J. Bernstein, vice-president; Henry W. Kraszewski, re-elected secretary.

Dwight Griswold has been appointed by Governor Lodge to the State Commission on Alcoholism.

Paul D. Rosahn, pathologist at the New Britain General Hospital and associate clinical professor of pathology at Yale Medical School, has been designated as the winner of the Second Annual Essay Contest of the American Dermatological Association. The contest was open to scientists generally. The prize consisting of a cash sum and a plaque was awarded for the best essay submitted for original work on some fundamental aspect of dermatology or syphilology. The winning essay, entitled "The Adverse Influence of Syphilitic Infection on the Longevity of Mice and Men" was based on investigations conducted at the New Britain General Hospital and the Yale Medical School, supported by grants from the National Institutes of Health. Dr. Rosahn presented his paper at the meeting of the Association at the Broadmoor, Colorado Springs, Colorado, April 23, 1952.

New Haven

Walter J. Baker of Naugatuck died at St. Mary's Hospital on May 21 following a long illness.

Henry Caplan, president of the Meriden-Wallingford-Southington Heart Association was tendered a testimonial dinner on May 21. The guest speaker was William H. Resnick of Stamford.

William Fischer had the signal honor of turning the first spade of earth preparatory to the construction of the new hospital in Milford.

Carl E. Johnson of New Haven has been appointed treasurer of the American Society for the Study of Sterility.

Windham

Frederick A. Beasley has been elected president of the Willimantic District Heart Association. The new vice-president is William S. Maurer.

News from Yale University School of Medicine

John F. Fulton, Sterling professor of physiology, has been elected president of the American Association of the History of Medicine.



To open congested air passages in hay fever

NEO-SYNEPHRINE®

HYDROCHLORIDE

. . . reduces nasal engorgement . . . relieves soreness

. . . promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (1/8)% solution, bottles of 1/2 oz.; 0.5% water soluble jelly, in 5/8 oz. tubes.

1. Von Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine.

Isadore Givner of New York City was guest lecturer on May 9 at the Yale University School of Medicine Postgraduate Courses in Ophthalmology. His subject was "Associated Skin and Eye Manifestations of General Disease," illustrated by one hundred slides, most of which were in colors.

The meeting was preceded by a clinical case which had been a diagnostic problem to the medical and surgical services, who had been admitted to the hospital on the chest service. Eye findings by the Section on Ophthalmology, in conjunction with skin lesions, led to a diagnosis by the eye section of Boeck's sarcoid which was confirmed by biopsy and other laboratory tests.

Dr. Givner commented on this case and answered many questions from the floor.

NEW BOOKS IN REVIEW

CURRENT THERAPY 1952—LATEST APPROVED METHODS OF TREATMENT FOR THE PRACTICING PHYSICIAN. Editor: *Howard F. Conn*, M.D. Consulting Editors: *M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; William J. Kerr; Perrin H. Long; H. Houston Merritt; Paul A. O'Leary; Walter L. Palmer; Hobart A. Reimann; Cyrus C. Sturgis; Robert H. Williams. Philadelphia and London: W. B. Saunders Company.* 1952. 849 pp. $11.

Reviewed by Michael S. Shea

From the point of view of either the general physician or the specialist in refreshing himself on the therapy outside his own specialty, this book offers itself as a handy desk companion. One is impressed with the popular list of contributors which generates faith in the contents. 100 new treatments in one year's contribution makes an imposing list, and shows the rapid and changing development in the field of therapy. Another feature that should lend itself to general consideration is the fact that the therapy is recounted by doctors with adequately conservative presentation, rather than by detail men, promoting drug sales. Since the market is flooded more and more by proprietary remedies, both ethical and otherwise, it seems inevitable that the publishers and editors should express no preference for the roster of drugs listed in the appendix. To my mind it emphasizes the multiple character of remedies with which the practitioner is besieged today.

In format it has 15 sections besides the appendix or 16th section and has an encyclopedic type of build for more ready reference which frequently obviates the need of the index.

Conservatism seems to be the tone of character throughout, as witness the approach to the therapy of common cold. Antibiotics are reserved for the severe cases after 48 hours during which time the old symptomatic type of treatment is advised unless definite indications are evident. The sections on infectious diseases and those of the respiratory system are both true to form in this respect. Section three offers a therapy that distinguishes it as thinking in terms of physiology and pathology of the cardiovascular system that is most likely the common ground of agreement of the men in that field today with its numerous controversial issues. It points up, more than any other section I believe, the individualization of each case. The section (IV) on haematology is all good but I like the discussion on erythroblastosis as considerably more simplified by Drs. Sacks, Weiner and Wexler than most of those I have read. They have attempted to blowtorch away the iron curtain of what we have up to date and emphasized the value of antenatal decisions to both pediatricians and obstetricians that a proper alert may be forthcoming. It emphasizes the value of specialized services and assumes adequate diagnostic acumen of G.P. who are expected to use them as indicated. Dr. Doan in particular has given much clarity to the purpuric states in a nutshell article.

The section on digestive tract diseases offers a practical approach to therapy and again places the physician on guard as a diagnostician. The diabetes section as we might well expect from the contribtuors constitutes a practical handbook on the therapy of diabetes that is good in the pocket of any intern or general physician.

The pages used on the endocrine system are well repaid if they only included thyroid gland therapy, but there is considerable substance besides this.

I would frequently enjoy having a reprint of section ten (X) on my desk or in my bag as I approach the multiple problems of allergy, which seem to be mounting daily. This is a good course on allergy therapy and on allergens which teaches us to become detectives just as does the following section on dermatology. Each section has a valuable formulary that is concise and adequate.

Much is condensed in the section of therapy of the nervous system. It is timely and up to date, especially as regards newer concepts of the degenerative diseases and the more generous use of vitamin therapy. While controversy exists as regards the quantity needed and the waste on heavy doses of these substances it seems to me evidence is accumulating that certain peripheral nervous and vascular states do benefit with larger doses than we find stated in the books. Some of the men there like Dr. Fox have seen the whole gamut of liver vitamins and now B_{12} from the early days of their use and observed wonderful improvement in nearly helpless cripples where the disease is reversible by adequate therapy.

And last but not least can we commend the section on diseases due to physical and chemical agents. It contains "something old and something new." It is likewise substance for a handbook valuable in every practictioner's pocket.

When one considers that these sections contain so much that would require wide search and reading on the part of a busy man, its condensed material offers a safe source on therapy.

AVOID "OVERTREATMENT DERMATITIS"
"Overtreatment dermatitis is today a prevalent and often disabling cutaneous disturbance."*
* Lane, C. G., "Therapeutic Dermatitis", New Eng. J. Med., 246:77-81, 1952
AVEENO...the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.
Send for samples E. FOUGERA & CO., INC. • Distributors • 75 Varick St., New York 13, N. Y.



CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years*, are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

Approved interneships (rotating), and residencies in medicine and obstetrics-gynecology; surgical residencies approved for training in preparation of surgical specialties; 215 bed general hospital, modern, well equipped; house staff allowed full range under proper medical supervision with wide diversification of diseases; excellent training, practical, in active surgical service and obstetrics-gynecology; full-time radiologist, pathologist and anesthesiologist; active interne and resident training program; this coastal city with an array of beautiful beaches is the mecca for vacationers in the East; recreational facilities, especially marine, unlimited. Full maintenance, uniforms, assistance in obtaining apartment if married; stipend—internes $2,400, assistant residents $3,000, residents $3,600. Class A medical school graduates only. The Lawrence and Memorial Associated Hospitals, New London, Connecticut, Joseph M. Wool, M.D., Chairman, Committee on Residents and Internes.

One is also impressed in its contents as pointing up the importance of diagnosis before therapy is approached.

DYNAMIC PSYCHIATRY. TRANSVESTISM—DESIRE FOR CRIPPLED WOMEN. (Volume Two). *Louis S. London,* M.D. *New York: Corinthian Publications, Inc.* 1952. 129 pp. $2.50.

Reviewed by FRANCIS J. BRACELAND

This is a small volume, second of a series, and is concerned entirely with a consideration of transvestism and the desire for crippled women. It is a short monograph and in it are contained fifty pictures, pen and pencil sketches, of various types of deformities from the phantasy life of a patient. It concerns actually only one patient and one particular type of perversion and it has little or nothing to offer the practitioner or the specialist outside of "an interesting case."

DYNAMIC PSYCHIATRY; BASIC PRINCIPLES. Volume one. *By Louis S. London,* M.D. *New York: Corinthian Publications, Inc.* 1952. 98 pp. $2.

Reviewed by FRANCIS J. BRACELAND

From the heterogeneous material making up a major portion of this volume, it is difficult to determine the direction in which the author is moving. The subsequent volume or volumes which the author evidently has in mind may clarify the matter, but at present the work shapes up as a somewhat unorganized review of the history of psychiatry and the theory of the libido, with occasional interpolations of personal views.

The volume is a 98 page affair with the following coverage: the evolution of psychotherapeutics from antiquity to the time of Freud; the meaning of the dream; psychology of the libido; the development of the libido in the child; and the libido in the adult. There is an abundance of straight quotation from various authorities. In the latter portion of the book, the author begins to present his own speculations on dynamics, with particular reference to the vagaries of the libido in various psychiatric disorders.

The book contains little of interest to the general practitioner.

*THE CLINICAL USE OF FLUID AND ELECTROLYTE.** *By John H. Bland,* M.D., Assistant Professor of Medicine, University of Vermont College of Medicine. *Philadelphia and London: W. B. Saunders Company.* 1952. 259 pp. with 75 figures. American Monograph Series. $6.50.

Reviewed by EDWARD NICHOLS

This discussion presents in great detail both fundamental knowledge and the more recent concepts related to the metabolism of fluid and electrolytes. The text is replete with Gamble type diagrams illustrating the distribution of water and electrolytes between the cellular and extracellular compartments of the body under a great variety of circumstances and conditions when the normal distribution is disturbed.

The bibliography is extensive and the references up to date. The monograph is divided into thirteen sections, the first of which deals with basic physiologic considerations. The other twelve sections deal with the application of these physiologic principles to specific conditions, diseases, and types of patients. One section is devoted to the physiologic effects of ACTH and Cortisone on body fluid and electrolyte. This form of treatment, although it may have certain advantages in the eyes of this reviewer, lends itself to repetition and loss of interest. This allocation of separate groups

*Incorrectly published in previous issue.

of patients and diseases into sections may tend to stimulate the idea that there is an inherent difference about the approach to such patients rather than encouraging the concept that the solution to any problem is best achieved by the application of the same physiologic principles to the immediate case at hand.

This discussion, like many, when questions of therapy arise, seems to pay only lip service to the marvels of renal function, which have previously been discussed in detail, by recommending the use of a variety of elaborate solutions to compensate for losses from various sources. A great deal of emphasis is placed on refinements devoted to the quantitative measurement and replacement of fluid and electrolyte losses. Although this may be feasible in infants and small children, in sick adults who cannot be weighed, the accurate collection of the necessary data is always difficult and subject to many errors and variables. The energy and attention extended on such details tend to lead to the treatment of calculations rather than the care of the patient on the broadest and most direct terms. A good deal of selectivity is required on the part of the reader in differentiating important from relatively unimportant points.

This monograph contains an enormous amount of information. It is not recommended as a practical guide to the clinical use of fluid and electrolytes.

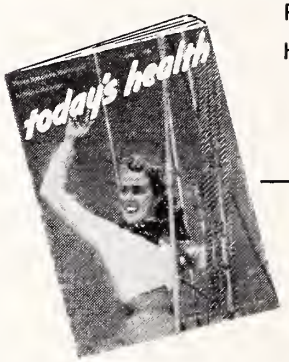
THE YEARBOOK OF PSYCHOANALYSIS. Volume 7.* Managing editor, *Sandor Lorand*, M.D. *New York: International Universities Press, Inc.* 1951. 271 pp. $7.50.

Reviewed by Francis J. Braceland

In the seven years of its existence, the Yearbook of Psychoanalysis has become a useful index of trends and advances in the field. Volume 7 continues the high standards of previous years, sifting from the voluminous literature of 1950 contributions of practical and theoretical importance. Included are good presentations of Freud's teaching and the early development of his thinking; a critical survey of post-Freudian dream contributions (part 2); and an excellent clinical paper on dream analysis. There follow papers on the application of psychoanalytic concepts to social science, on the development of the mental apparatus, on preconscious mental processes, psychodynamics, oral aggressiveness and ego development, and psychosomatic symptoms. Other themes of interest are the climacterium; the role of anxiety in depersonalization; termination of analysis; the role of emotions in the development of language and the acquisition of a second language; and psychoanalytic aspects of bureaucracy.

These selections, 21 in number, are brief, well written and informative. The Yearbook should be kept in mind as a useful source of reference.

*Incorrectly published in previous issue.

today's health a must!
for your reception room


Physicians' Half-Price Rates

4 years	$4.00
3 years	3.25
1 year	1.50

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn · Chicago 10, Illinois

49 MILLION AMERICANS VOTED

BUT

47 MILLION AMERICANS STAYED HOME!

That's What Happened in the Last Presidential Election

IF YOU WANT A VOICE IN YOUR GOVERNMENT

SPEAK UP! REGISTER! VOTE!

Table of Contents : August 1952

Address of the President of the AMA — John W. Cline, M.D. 577

New Theories of Retinal Venous Thrombosis — Henry L. Birge, M.D., Hartford 582

Infectious Hepatitis in Pregnancy — Hoyt C. Taylor, M.D., Meriden 587

An Evaluation of Telepaque A New Cholecystographic Medium — Robert M. Lowman, M.D., and Howard W. Stanley, M.D., New Haven 591

Group Practice of Anesthesia — Mario L. Garofalo, M.D., Pierino F. D'Elia, M.D., Norton A. Kazanjian, M.D., Leopold M. Trifari, M.D., and Ulysses V. Golia, M.D., New Haven 594

Address of Alfred V. Bodine, President, Connecticut Manufacturers Association 599

EDITORIALS

Dean Vernon W. Lippard 606
Dr. John W. Cline 606
New Drugs for Tuberculosis 608
The National Fund 610
Clinical Congress—1952 610
The Hartford Circus Fire: Lawyers and Doctors 610
Olin West—Physician, Statesman, Friend 611

DEPARTMENTS

Progress in Clinical Medicine
Newer Aspects of Fertility and Sterility Problems
Robert H. Hepburn M.D., Hartford 612
The President's Page 616
The Secretary's Office 617
Public Relations 619
News From Washington 626
Military Affairs 630
From Our Exchanges 632
Letters to the Editor 654
Our Neighbors 654
News From County Associations 656
New Books in Review 658

MISCELLANEOUS

Program 27th Connecticut Clinical Congress 603
Obituary
Thomas J. Roche, M.D. 634
Roster—Woman's Auxiliary 635
Special Notices 650
The Doctor's Office 652

CONNECTICUT MEDICAL SERVICE, INC.

345 WHITNEY AVENUE — NEW HAVEN 7, CONNECTICUT

W. H. HORTON, M.D.
GENERAL MANAGER

Dear Doctor:

The Professional Policy Committee has requested me to bring to your attention that with the inclusion of in-hospital medical care benefits, every physician in Connecticut is now able to actively support CMS, the voluntary medical care plan sponsored by the Connecticut State Medical Society and give his patients the benefits of CMS coverage.

Since the in-hospital medical care program was begun on June 1, we have added 47 Participating Physicians. Currently, from 3 to 5 new applications are being received each day. It is our hope that we will promptly secure as high a percentage of participation by physicians who are engaged in non-surgical practices, as has been obtained by those in the surgical and obstetrical fields (96.4%).

A phone call or note to the Connecticut State Medical Society, 160 St. Ronan Street, New Haven UN5-0587 or the CMS Home Office, MA4-9861 will bring Physician's Agreement forms promptly to your office.

We would like you to be in support of the Doctors Plan for medical care in Connecticut.

Very truly yours,

W. H. Horton, M.D.
General Manager.

WHH/md

ALL ENROLLMENT AND BILLING FUNCTIONS OF CMS ARE HANDLED BY CONNECTICUT BLUE CROSS AS AGENT

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI AUGUST, 1952 No. 8

ADDRESS OF THE PRESIDENT, JOHN W. CLINE, M.D.

To the House of Delegates, AMA, June 9, 1952

THE past year has been busy and somewhat strenuous for your President. It has carried me to many states and all parts of the country.

It has been gratifying to observe the growing unity and increasing vigor of the profession. The degree varies in the different states but the trend is apparent everywhere.

The past year represents one of great achievement in medicine. There have been important additions to our scientific knowledge and we have learned to reduce farther the latent period between the establishment of scientific fact and its practical application in diagnosis and treatment. Rapid dissemination of information by means of meetings and publications and the increased cooperative effort by investigators in common and differing fields have contributed to this process. Scientific medicine now is coordinated to a degree never previously attained.

Medical education at all levels—undergraduate, graduate and postgraduate—has continued to improve. Graduate education has suffered to some degree as a result of defense mobilization and we must plan now to provide opportunity for those in the Armed Forces to complete their training when returned to civilian life.

Perhaps the most significant advance is to be found in the field of postgraduate education. More planned postgraduate courses have been offered and, in some instances, these have been carried to the physician in his home community. The attendance at meetings, which have been better organized and of high quality, has increased.

Medical care has increased in quantity as well as in standards. The American people enjoy more abundant and better medical care than ever before.

The ratio of physicians to population has increased and there is better distribution of doctors. Improved transportation, better facilities and greater use of auxiliary personnel have permitted the physician to make better use of his time and render better care to more people over a wider area.

The interest of medical students in general practice and in rural practice has been fostered by the medical schools, the state associations and the American Medical Association. These efforts coupled with the placement agencies of our state and national organizations and the increased assumption of responsibility by local communities for providing medical care, have resulted in placing many physicians in areas in need of their services.

Until comparatively recently inducing physicians to locate in places needing them was considered to be solely the responsibility of the profession. It now has been demonstrated that young, well trained physicians will go readily to communities in which they are able to practice medicine of the high quality learned during their medical school and hospital years. They will remain if the community will avail itself of their services throughout the year and if living conditions and educational facilities are adequate to provide satisfactory surroundings in which to raise a family.

There are abundant examples of success in obtaining and holding physicians when the community undertakes its portion of the burden of improving the facilities for practice and providing adequate educational opportunities for children. These serve to focus attention upon certain essential aspects of community life.

Plans for protection against the costs of illness have grown and improved during the past year. More than 85,000,000 Americans now have Blue Cross or other hospital coverage, 65,000,000 have surgical and 28,000,000 medical and surgical protection.

During the year, additional millions of Americans have enrolled in these programs, demonstrating that American problems can be solved by American

methods and far more successfully than by resorting to government for a partial solution restricted within the rigid framework of legislation.

The multiplicity and elasticity of our plans stimulates experimentation and encourages the orderly process of evolution. This ultimately will provide us with a plan or plans which will be generally recognized as the most nearly ideal for our people.

The plans for prepayment have undergone considerable development in the past year. Coverage against economically catastrophic illness has become more general. Individual coverage is more available and experiments in covering the aged are under way. The rural population has wider protection. More must and will be done in these areas as time passes. Gaps have existed and some still exist but these are being closed.

Over the country one finds variation in the interest of the profession and the backing it gives to the voluntary insurance program. On the whole it is good and is improving.

The voluntary plans fill a great need and render a great service to our people. On this basis alone they deserve our full support. Unquestionably they are far from perfect and defects exist in some plans. Where changes are needed let us strive to bring them about in a constructive fashion.

Destructive criticism and withholding support and cooperation interfere with proper development and damage the entire program. Injury to the voluntary movement would jeopardize our future freedom.

Opinion is almost unanimous that a strong and successful voluntary insurance program is our greatest bulwark against the socialization of medicine. This opinion is held by many of our friends in other fields of endeavor and in public life. It is shared by those who would destroy the high standards of American medicine by placing it under bureaucratic domination. Some of these belittle the accomplishments of the program and some have tried to interfere with its development because they realize that it stands as a barrier against the accomplishment of political medicine.

We have recognized and accepted our responsibilities to provide the American people with medical care of continuously improving quality and to make that care more easily available to all. We must continue our efforts.

On the other hand, there is also growing recognition of a coexistent responsibility on the part of the public. It has been said that the plans for extension of medical care are solely the responsibility of the medical profession. It is essential that the public, the plans and the hospitals assume their portions of the burden. The provision of medical care is not a one-way street and others must meet their obligations as well.

In the course of twenty years of dealing with medical problems on the local, state and national planes, I have watched these problems multiply and become more complex at all levels. As medical care and health have become more prominent in the minds of the people this change has been inevitable. As public interest has increased in these matters, we have come more closely under public scrutiny. As medical affairs have become more important our relations with other groups have become more important and the operations of the American Medical Association have become more important.

These activities have been strengthened in many ways. A large number of individuals have been responsible. They are too numerous even to mention at this time although I have drawn attention to some of their activities during the year through the medium of the President's Page. The headquarters staff consists of almost nine hundred loyal, hard working employees distributed in twenty departments. With the exception of the purely organizational departments, all are working full time directly or indirectly in the public interest.

I cannot allow this opportunity to pass without paying my respects to our calm, efficient and extremely able secretary and general manager, Dr. Lull, and to his very capable, energetic and loyal assistant, Dr. Howard, who direct the staff. During the past year numerous changes have been made in the interests of more efficient operations.

The quality of *The Journal* has continued to improve under the admirable direction of the editor, Dr. Austin Smith. In my travels about the country I have heard many compliments, few criticisms of *The Journal* and almost unanimous approval of the changes he has instituted. *J. A. M. A.* has increasingly justified its reputation as the most highly respected and most widely read medical journal in the world.

The Board of Trustees is composed of fine, sincere and able men who labor arduously and with serious purposes dealing with the many matters demanding their attention. As the problems of medi-

cine have multiplied the agendas have increased in length. It is only by close application to its work, under the capable and efficient direction of its splendid and devoted chairman, Dr. Murray, that it is able to perform the many tasks assigned to it. I wish to express my deep appreciation to the Board and its chairman for the excellent record of accomplishment of the past year.

To you, the members of the House of Delegates, I wish to express my compliments and my appreciation of the character of your deliberations. In your meetings you have considered and debated many matters. The serious responsibility of determining the basic policies of American medicine is yours. The decisions you make and the methods of expressing them are of great importance. The thought, diligence and care you have devoted to your transactions have clarified the position of medicine and have built well for the profession.

During the past year more attention has been paid to the relationship of medicine to other professions. The association with other groups concerned with the care of the sick has become closer. Problems still exist in certain areas of contact but progress has been made and is being made in dealing with them. Some will require long periods for complete solution.

No problem is too difficult to solve if patient men of good will approach it in a spirit of cooperation. An excellent example is the successful conclusion of the negotiations in the establishment of the Joint Commission on Hospital Accreditation.

The medical profession and the hospitals are interdependent. What affects one affects the other. There is growing concern over mounting hospital costs and the hospitals have been unduly criticized because of them. We can do much to dispel misconceptions by explaining to our patients the reasons for this situation. About 65 per cent of hospital costs are attributable to salaries and wages. As scales of compensation have risen, costs have risen correspondingly. In addition every item which the hospital must purchase is more expensive due to the spiral of inflation which involves our entire economy.

On the other hand, certain hospitals continue to engage in the practice of medicine in defiance of established principles and in contravention of the law in most states. There is, I believe, widening recognition by hospitals that the practice of medicine is the practice of medicine whether performed within or without the hospital. We recognize the right and the necessity for hospitals to derive income from certain departments staffed by physicians and ethical arrangements have been worked out whereby the rights of all concerned are respected. The hospital must not become dominant in the practice of medicine. This appears to be the objective of a small minority of administrators and trustees.

The curricula of modern osteopathic schools now are patterned largely after those of schools of medicine. The level of education provided by some has improved since the conclusion of the last war. There have been recent discussions between a committee of our Board and a similar group of the American Osteopathic Association. The representatives of the osteopathic profession express a desire for our assistance in further improving the education of students in osteopathic schools. In thirty-odd states the licenses granted to osteopathic physicians approach or approximate, for practical, legal purposes, those granted to doctors of medicine. We cannot accept or recognize the basic concept of osteopathy as a valid method of treatment of disease. The osteopathic profession apparently appreciates that fact as evidenced by the progressive reduction of the emphasis upon the teaching of osteopathy in favor of instructions in medicine and surgery. Removal of the stigma of cultism would hasten that process.

It is my considered opinion that the AMA Council on Medical Education and Hospitals should be permitted to aid and advise schools of osteopathy and that we should facilitate the opportunities of these schools to improve their faculties by removing any barrier of unethical conduct on the part of doctors of medicine who may teach in these schools. I recommend that the House take action to implement these suggestions.

We must continue to strive for greater cooperation between medicine and the dental, nursing and pharmaceutical professions. Closer relationship will work to the advantage of all.

The public relations of medicine have improved but much remains to be done. In one sense, the esteem in which medicine is held by the public is the total of the patient-physician relationships of the entire country. The good deeds of the ninety-five per cent or more of the profession go unnoticed and are taken for granted. The transgressions of a very small proportion of physicians do untold harm to the entire profession.

Our Code of Ethics is not a body of law but is a pattern for conduct. In a sense it is the code of the gentleman in the practice of medicine. Even if it did

not exist it would not be violated by many because the vast majority of our members are gentlemen.

We have long recognized and subscribed to the dual obligation of the physician to his patient: To render to the patient the best possible medical care and to deal fairly with him in all ways. Unfortunately there are a few of our colleagues who do not respect these obligations.

When these are encountered they must be thrust from the company of gentlemen. There can be no compromise with dishonesty or unethical conduct. We owe forthright action not only to the public but to ourselves. Respect, to be maintained, must be deserved.

Grievance committees have gone a long way in improving the situation but the mere existence of such committees is not enough. They must be composed of physicians who are respected, not only for their professional attainments but, also, for their character, impartiality and courage. These committees must be active, easily available and the public must be informed of them and the means of access to them.

These provisions will do much to inspire public confidence. The work of these committees can be greatly reduced if the physician will discuss all aspects of his services to the patient at the outset of his contact with him. This procedure will reduce misunderstandings to a minimum and since most complaints against the profession are based upon misunderstanding these will be greatly lessened.

There also has been a great change in the public position of medicine. Medicine and the American Medical Association had been subjected to years of the most vicious, systematized campaign of vilification ever waged against a respectable profession and organization devoted to the public interest. We were not prepared to meet these onslaughts. You all recall vividly the situations which confronted us in December 1948.

Conditions have changed. We are stronger, more unified and are better able to prevent the destruction of the high standards of medical care inevitable in socialistic schemes of its administration. Medicine has become a significant force in American life.

The vigorous support of physicians and others throughout the country who perceived the danger to the future quality of medical care has brought about this transformation. This activity stemmed largely from the National Education Campaign so ably directed by Clem Whitaker and Leone Baxter. They deserve great credit for their splendid performance in the face of many difficulties. I wish to express the gratitude of American medicine and my own personal thanks to them for an important job well done.

When one thinks back over the period of three and one half years and observes the change, he cannot help but be impressed. In that short time medicine has changed from an ideal whipping boy for any demagogue who wished to make a rabble rousing speech into a strong body able to respond with sufficient vigor and effectiveness to make the profession an unwise object to attack.

In the long view an even greater contribution, perhaps, has been the insistence that we meet the problems confronting medicine on a positive, constructive basis and that the Association develop a strong public relations department of its own to deal with matters of fundamental importance now and in the years to come. I have described the department and its operations in a President's Page and believe it to be growing in effectiveness.

As a result of our efforts and the increasing strength of medicine, those who would destroy our capacity to render the best care to the American people have altered their strategy. As far back as the 81st Congress it was apparent that no all-inclusive bill for socialized medicine could be passed.

Our opponents realized this earlier than did we and altered their course correspondingly. They ceased the effort to overwhelm us by frontal attack and resorted to more subtle flanking maneuvers by concentrating upon the so-called fringe bills, the most important of which was federal aid to medical education. To date we have been successful in preventing legislation which would have placed the medical schools of this country in imminent danger of bureaucratic control.

We recognize that our medical schools are in financial distress and we are making an effort to alleviate this situation through the American Medical Education Foundation and the National Fund for Medical Education. The results to date, this year, are more encouraging than in the first year. Every one of us owes a great debt to medical education and it must have our fullest support. Medical education is every doctor's business.

Another manifestation of the recognition of changed conditions has been the politically inspired appointment of the President's Commission on the

Health Needs of the Nation. There is adequate evidence to establish that it was created for the purpose of removing a very troublesome issue from public consideration during an election year. This course of action was predicted by a competent observer months in advance and we now have sufficient information of the immediately preceding events to know this to be the case.

Doubt remaining in the mind of anyone concerning the political motives behind the creation of the Commission should have been dispelled by the President's recent unwarranted, undignified and intemperate attack upon the American Medical Association. It is apparent that the Administration's intention to socialize medicine has undergone no change. It is obvious that it will resort to parliamentary legerdemain to accomplish what cannot be achieved by more direct and honest methods. The angry petulance of the outburst provoked by the Association's exposure of the political trickery reveals the true colors of the Administration.

The Commission was assigned an impossible task to perform within the period of time allotted and has been described as an organization whose principal accomplishment would be to survey all preexisting surveys to decide if additional surveys were needed. I have discussed the appointment of this body at length elsewhere.

The Board of Trustees was unanimous in denouncing its creation and the political purposes behind it. Primarily out of deference to the chairman of the Commission, the American Medical Association has made the information in its possession available to the Commission and authorized officers and employees to testify before it while completely and thoroughly disapproving of its appointment.

After such testimony has been given, by participation in panel discussions, agents of the Commission have made purported digests of the testimony. In certain instances these have ignored completely most of the statements made to the Commission. Participants have then been requested to approve or amend the distorted digests. To amend the statements adequately would require days of effort in addition to the time occupied by travelling to and from Washington and testifying. The digests have the appearance of preconceived editorialized opinions of the person or persons preparing the abstracts and do not report fairly the points of view presented to the Commission. It is obvious that this procedure is not compatible with fair presentation of the facts. I bring this situation to the attention of the House to the end that it may be able better to evaluate the ultimate report.

In view of the magnitude of the task, the limited facilities and the short period of operation—characterized by the Commission chairman as "too big a job for one year" any report emanating from it must be carefully examined. It will not only be based upon inadequate time and opportunity for study but may have all the misleading and dangerous attributes of a snap diagnosis. The report may be voluminous and impressive in appearance but probably will reflect the preconceived ideas of a majority of the Commission. It must be scrutinized with great care.

Let us not be misled by the apparent quiet of the moment. Our batttle is not yet won. Complacency could well be a fatal error. I recall clearly the false security of 1946 at which time it was said that socialized medicine was "as dead as a dodo." Two years later American medicine confronted the gravest crisis in its history. There also are important external threats as will be detailed to you by Dr. Bauer.

Few persons realize the distance we have travelled, as a nation, down the road to socialism. As physicians we know that in the course of many diseases a point is reached where the changes of structure in the tissues become irreversible and restitution of normal function becomes impossible. The disease of socialism which affects our body politic is at the present time not far from that point.

This may well be the year of decision. Unless the trend toward an all powerful government progressively extending its influence into our daily lives, limiting our horizons and sapping our initiative is halted, the changes in our political, economic and social structure will soon have reached the state of irreversibility. If this occurs we will have sacrificed the most precious heritage any nation ever had, and for a mess of socialistic pottage.

Medicine's firm stand has encouraged others to resist this process. At the present time we have more and stronger allies than ever before.

I urge every citizen who values the American tradition of freedom, opportunity and dignity of the individual to utmost effort this year. This may be our last chance to preserve those essential ingredients of American life.

Our leadership has inspired others. We have a great responsibility and a great opportunity. Let us not be in default.

NEW THEORIES OF RETINAL VENOUS THROMBOSIS

HENRY L. BIRGE, M.D., *Hartford*

The Author. *Associate Ophthalmologist, Hartford Hospital, Assistant Clinical Professor of Ophthalmology, Yale School of Medicine*

VENOUS thrombosis in the retina, formerly called "retinal apoplexy," was first described in 1878.[1] The causes of this condition were never clearly demonstrated, although early authors were divided between two contentions: the one, following Coats'[2] belief that most cases were due to thromboses, and the other, supporting Verhoef's[3] theory that intimal proliferation was responsible for this type of pathology.

Modern theories should consider thromboses in any organ from the point of view of both diseases of the veins, as well as the blood itself. Anything which produces stasis in the flow of blood through an organ plays a causative role in the thrombosis of the veins of that organ. Irrefutable evidence of this fact is found throughout medical literature.[5]

TABLE I

CLASSIFICATION OF POSSIBLE ETIOLOGIC FACTORS IN RETINAL VENOUS THROMBOSIS

Infection (direct or focal)
Neoplasm (8)
Surgery (rare)
Cardiac decompensation
Trauma
Arteriosclerosis
Diabetes
Hypertension
Glaucoma
Polycythemia

We were not satisfied with our therapeutic results after using anticoagulant therapy for retinal venous thrombosis, nor with the results of x-ray treatment, and in searching for new ideas we noted that many of the cases we saw were associated with venous engorgement and cyanosis in the unaffected eye.

Improved laboratory procedures for determining the quantity of various blood elements led to the use of "blood volume" estimations, and revealed that many of our cases showed mild degrees of polycythemia.

We now believe that the use of these more accurate laboratory methods indicate that mild degrees of polycythemia exist more frequently than were formerly recognized, and that the polycythemia predisposes these patients to retinal (as well as other) thromboses. Acceptance of this theory offers both a method of preventing retinal thromboses and, as we will show in our case reports, a satisfactory method of treatment of retinal vein thromboses.

It must be stated that polycythemia has long been known to cause retinal hemorrhages; it is our contention that mild degrees of polycythemia have gone unrecognized, and that modern laboratory procedure no longer permits us to omit its diagnosis and treatment.

Recent classifications[4] of retinal venous thrombosis in the literature have listed three types of etiology: (a) inflammatory; (b) tuberculous or luetic; and (c) focal infection.

In all three types, angiosclerosis, and often hypertension, existed and it was mentioned in passing that increases in the platelet count, as well as the red blood cell count, were often encountered.

We suggest that the primary cause of the thrombosis has been the sluggish flow of the blood and that other factors are secondary, although not to be neglected. Our cases complicated by diabetes have all been more serious.

Bertha Klein[7] discusses the mechanism of ophthalmic venous thrombosis with relation to anticoagulant therapy and lists four categories.

It can be seen that a study of the ocular fundus will reveal classes I, III and IV, and that a study of the blood elements will establish class II. We recommend that the blood study include the "blood volume" as well as a search for abnormal blood cells. Blood sugar and uric acid should also be determined. Our cases show a much greater incidence of polycythemia than has previously been suggested.

Presented at the fourth Pan-American Congress of Ophthalmology, Mexico City, January 6-12, 1952

Table II

TYPE OF THROMBOSIS	ANTICOAGULENT THERAPY
1. Occlusion of vein by compression from outside	Useless
2. Blood dyscrasias	Indicated
3. Following arterial spasm; stagnation thrombosis	Indicated with vasodilators
4. Inflammatory (of vein) thrombosis	Contra-indicated Use antibiotics and/or procaine

Table III summarizes the findings in our cases of polycythemia associated with retinal or cerebral venous thrombosis. Seven of the ten cases are retinal thromboses; two are cerebral thromboses; one is a cataract case, reported to illustrate that the finding of polycythemia before surgery will prevent complications, even in patients with other venous disease. Four of the seven retinal thromboses had satisfactory visual improvement, and one of these was a central vein thrombosis.

In such a small series no conclusions will be drawn on the basis of visual improvement.

In our practice an important cause of spontaneous

Table III

INCIDENCE OF POLYCYTHEMIA IN TEN CONSECUTIVE CASES OF THROMBOSES AFFECTING THE VISUAL ORGANS, RETINA AND BRAIN

CASE	EYE DIAGNOSIS	HEMATOCRIT	TOTAL BLOOD VOLUME	RBC VOLUME	BLOOD PRESSURE	GENERAL DIAGNOSIS	VISION
1. C.M. Age 50	Branch Venous Thrombosis Retina	56	Excess 1750 c.c.	Excess 1610 c.c.	210/110	Diabetes Polycythemia Overweight	Improved to 20/25
2. H.R. Age 53	Central Venous Thrombosis Retina	50	Normal	Excess 500 c.c.	130/98	Polycythemia Dental caries Diabetes Overweight	Not improved
3. P.J.B. Age 43	Branch Venous Thrombosis Retina	39	Deficit 850 c.c.	Deficit 1200 c.c.	118/76	Traumatic Trombosis	Improved to 20/20
4. P.J. Age 49	Right Hyperphoria 10 prism diopters		Excess	Excess 614 c.c.		Cerebral Venous Thrombosis Polycythemia	Improved
5. S.C. Age 59	Central Venous Thrombosis	53	Excess	Excess	105/65	Diabetes Polycythemia	Improved to 20/20
6. L.S. Age 80	Central Venous Thrombosis Retina	45	Excess		180/90	Hypertensive Arteriosclerotic Cardiovascular disease Polycythemia	Not improved
7. M.S. Age 74	Central Venous Thrombosis Retina		Excess		180/90	Hypertension Arteriosclerosis Polycythemia	Not improved
8. M.M. Age 68	Branch Venous Thrombosis Retina	45	Excess 664 c.c.	Excess 468 c.c.	200/104	Polycythemia Hypertension Arteriosclerosis	Improved to 20/50
9. T.N. Age 54	Homonymous Hemianopsia	48	Borderline		110/80	Prostatectomy Cerebral Thrombosis Polycythemia	Not improved
10. E.R. Age 50	Cataracts	53	Excess 492 c.c.	Excess 680 c.c.	154/80	Femoral Vein Thrombosis Cataracts Polycythemia Overweight	Improved to 20/20

or primary retinal venous thrombosis has been polycythemia, either alone or in combination with diabetes. Venous disease alone, or in combination with arterial hypertension, may be a predisposing factor along with focal infection; but the sluggish flow of thick blood is probably the primary cause of the syndrome in cases where actual trauma is nonexistent. Furthermore, it is possible to remove the polycythemic factor, whereas the arteriosclerosis, and often the hypertension, are irreversible. And most important—the polycythemic factor may be removed before a thrombosis occurs!

Further evidence of the importance of polycythemia in all vascular disease comes from the work of Stroebel, Hall and Pease[6] who found that 56 per cent of the deaths from polycythemia were due to either hemorrhage or thrombosis in 32 cases in which postmortem examination was performed.

The striking fact that 56 per cent of polycythemics die from either hemorrhage or thrombosis makes it probable that a higher percentage of minor hemorrhages and thromboses (ocular) have a polycythemic etiology.

Table IV

CAUSE OF DEATH IN THIRTY-TWO PATIENTS WITH PRIMARY POLYCYTHEMIA

	NUMBER	PERCENTAGE	
THROMBOSIS			
Coronary	8	25	
Mesenteric	3	9.4	
Hepatic	1	3.1	
Hemorrhage			56.3
Cerebral	3	9.4	
Gastrointestinal	3	9.4	
Chronic myelogenous leucemia	4	12.5	
Malignant tumors	4	12.5	
Peritonitis	2	6.2	
Others	4	12.5	

The ophthalmologist is concerned with all forms of polycythemia, not merely polycythemia vera. Primary polycythemia is a sustained condition of elevated erythrocyte count and elevated erythrocyte volume in the presence of normal or increased total blood volume. Secondary, or relative, or transient polycythemia may produce ophthalmic disease as well as primary polycythemia vera.

Our ten cases were treated only with phlebotomy. We did not use the radioactive isotope, phenylhydrazine or roentgen therapy. Phlebotomy to produce normal blood volume may be repeated whenever necessary; every six weeks, if required, and, after normal blood volume is attained, dietary measures often control the situation in the secondary polycythemias.

Thrombosis is so common in polycythemic states that the ophthalmologist is justified in seeking laboratory confirmation of his suspicions when he notes enlarged, cyanotic, retinal veins.

The indications for phlebotomy as a preventive, or therapeutic measure, against thromboses in either medical or surgical problems are considered to be:

1. Elevation of the erythrocyte count of more than 6,000,000 cells per cubic mm. of blood.

2. Elevation of the erythrocyte volume at more than 55 per cent in the presence of normal or increased total blood volume.

Other findings in polycythemia are splenomegaly, hyperuricemia (uric acid level of more than 6.0 mg. per 100 cc. of serum) and a total blood volume of more than 100 cc. per kilogram of body weight. In our laboratory, the Evans Blue Method of determining blood volume was used.

SUMMARY

Ten consecutive cases of retinal venous thrombosis and cerebral thrombosis affecting visual pathways are reported.

The incidence of polycythemia is sufficient to warrant a change in our thinking when considering venous thrombosis of the visual system.

Recent articles have suggested that the prognosis for life after a retinal venous thrombosis is only 5-8 years (Moore).[9] This may be modified if the cause of thromboses is removed.

Our results of therapy compare favorably with other known treatment. We do not favor anticoagulant therapy and suggest more frequent study of the "blood volume" with necessary changes in the blood elements as indicated. This therapy seems to provide better results, less danger, and less expense than anticoagulant therapy. The only case in which we used anticoagulants in the past few years was that of a young man who developed bilateral venous thrombosis subsequent to extraction of infected teeth. He received intravenous procaine, antibiotics and small doses of anticoagulants with return of vision to 20/50 in one eye. He had no polycythemia.

Cases in which blood volume studies should be performed are those in which the retinal veins are enlarged, engorged and slightly cyanotic. The practice of checking blood volume preoperatively in patients who may be liable to thrombosis in other

areas besides the retina may prevent complications in ocular surgery.

A fact of striking significance in polycythemia is that 56 per cent of the deaths have been proven by autopsy to be due to thrombosis. This makes it probable that an even higher per cent of smaller thromboses are due to polycythemia.

Ophthalmologists must realize that not only polycythemia vera, but also transient relative states of polycythemia may contribute to thromboses that affect the visual organs.

CASE HISTORIES

1. C. M.: age 50, male.

This patient came in for a refraction, stating that his right eye had been poor since childhood. He had no complaints referable to the left eye. Examination showed a thrombosis of the left inferior temporal retinal vein. Vision was: Right: 20/25, Left: 20/20. Refraction was:

Right: $-.50\ -4.00 \times 32 = 20/25$
Left: $-.50\ -1.00 \times 165 = 20/20$

The veins in both retinae were rather markedly engorged. There were a few small diabetic-type retinal hemorrhages present, in addition to scattered hemorrhages and exudates from the thrombosis. Patient was hospitalized where total blood volume showed an excess of 1750 cc. The RBC was 1610 cc. excess. Hematocrit was 56 and blood pressure 210/110. Patient was 10–20 pounds overweight. A phlebotomy was performed which reduced his blood volume to normal. Blood sugar was 123 and he was put on a diabetic diet. His blood pressure improved somewhat after he had been hospitalized for a while. He reduced his overweight status. In three months the vision in both eyes was still 20/20 with correction. Hemorrhages were absorbing nicely. There were no further complications.

2. H. R.: age 53, male.

Chief complaint was seeing a light in front of his left eye. A diagnosis of central vein thrombosis of left eye was made. Vision was 20/20 in each eye. Visual fields showed an early Bjerrum type of scotoma. Retinal veins were found to be tremendously engorged. Several large hemorrhages and a few small round diabetic hemorrhages were present. Four branch veins were involved in the thrombosis. Patient was hospitalized where his blood volume was found to be elevated. RBC was found to be 500 cc. in excess. His hematocrit was 51 per cent. Blood sugar 134 and blood pressure 130/98. He was considerably overweight.

Vision continued to fail as the thrombosis extended and the retina died. His blood volume and hematocrit returned to normal following a phlebotomy and his diabetes was controlled.

On one occasion, two weeks after his initial thrombosis, he suffered an allergic attack which caused sneezing at frequent intervals. On the following day he developed glaucoma in his left eye. Tension was elevated to 48. This glaucoma was felt to be due to vascular stasis in the iris which was brought about by the prolonged sneezing. Tension subsided in the course of 3 weeks as the vascularization of the iris decreased. Vision never improved.

3. P. J. B.: age 43, male.

This patient was admitted with a sudden loss of vision in the right eye. Diagnosis was acute thrombosis of the retinal veins of the right eye. Disc was swollen and elevated. All the veins were markedly dilated and tortuous. Numerous small retinal hemorrhages, some of which resembled diabetic types, were present. He was hospitalized where blood volume study revealed hematocrit 39 and a deficit of 1200 cc. in RBC and total blood volume deficit of 850 cc. Blood sugar was normal. Complete physical examination showed he was otherwise negative.

In discussing the cause of this thrombosis which occurred in the absence of polycythemia in this healthy young man, the patient felt that it had occurred shortly after he had been yelling loudly at some of his children. This explanation was considered logical due to the fact that he had, no doubt, over distended the veins of his head and neck from this exertion.

His thrombosis received no treatment other than bed rest and vision returned to 20/20 in each eye after six weeks.

4. P. J.: age 49, male.

This patient was admitted because of double vision which came on suddenly. The double vision was caused by a 10 prism diopter hyperphoria which occurred following a cerebral vascular accident. Blood volume was excess of 614 cc. RBC. Total blood volume was normal. Hematocrit 52.

This case is included with the Retinal Venous Thrombosis group because we believe the same vascular pathology occurred in the brain and could give rise to his double vision. There was at no time any evidence of hemorrhages in the retina, although there was considerable venous dilation and a diagnosis of polycythemia was made on ophthalmoscopic findings. This patient was seen in consultation by a neurologist. It was decided that he had too small an amount of polycythemia to use radioactive isotopes.

Four months after the initial cerebral thrombosis the right hyperphoria had reduced to 6 diopters. Vision in each eye was 20/20 and the patient was comfortable with 4 diopters BD prism.

5. S. C.: age 59, male.

Chief complaint: Patient lost vision in right eye 4 days before admission. Vision was 20/100 in right eye and 20/20 left eye. There was choking of the right disc with thromboses of superior and inferior retinal veins, together with venous engorgement of the veins of the left eye. Patient was a known diabetic, taking 74 units of insulin daily. Hematocrit was 53; blood pressure 105/65. Following the usual treatment and control of his diabetes 4 months later, the vision had returned to 20/25 in the right eye and was still 20/20 left eye. At this time slight pallor of the right disc was noted, but left veins were normal. There was no glaucoma.

6. L. S.: age 80, female.

This patient lost vision in left eye one week prior to admission. Diagnosis was central venous thrombosis in left eye. She had chronic simple glaucoma in both eyes. On pilocarpine in both eyes the tension remained controlled

between 25–29. There was no treatment for extensive decompensated heart disease. She has marked arteriosclerosis. It was not felt advisable to do a phlebotomy at this time. Treatment for the circulatory disease, heart failure and glaucoma was carried out. There was no improvement in vision of the left eye. Vision in right eye remained at 20/40.

7. M. S.: age 74, male.

Six months prior to admission this patient had a sudden loss of vision in the right eye. He had poor vision in left eye for 27 years previous. Vision in both eyes was counting fingers.

Diagnosis was central venous thrombosis of the right eye, old optic atrophy of left eye. He had received extensive anticoagulant therapy with no improvement in the thrombosis. He had extensive venous dilation in the right eye when we saw him six months after onset. Vessels in left eye were attenuated. He received a course of BAL for 2 weeks and the vision in his old atrophic left eye returned to 20/50. His general diagnoses were hypertension with severe arteriosclerosis, and polycythemia. The question as to whether he would have had some improvement in the vision of the eye with venous thrombosis had the polycythemia been recognized and treated sooner is raised.

8. M. M.: age 68, female.

Chief complaint was watering and poor vision in left eye. Gradual onset. Examination disclosed thrombosis of the two superior branch veins in left retina. At the star figure of the macula fresh exudates were seen. Vision was counting fingers in left eye and 20/20 right eye. Patient was hospitalized. Blood volume revealed that she had an RBC excess of 468 cc. and an excess of 664 cc. in total blood volume. Hematocrit was 45; blood pressure 200/104. There was no evidence of diabetes. Phlebotomy was performed and after two months the vision in left eye had improved to 20/50, with vision in right eye still 20/20. There was no glaucoma.

9. T. N.: age 54, male.

This patient was seen by us because of defective vision due to a right homonymous hemianopsia. Vision was 20/100 in each eye. A field defect involved the central area. Retinal veins in both eyes were engorged, dilated and cyanotic. The cerebral vascular accident which caused the hemianopsia occurred three days after a prostatectomy. Blood volume studies showed this case to be a borderline polycythemia. The case is included to emphasize the importance of checking the blood elements before any surgery.

10. E. R.: age 58, male.

This patient had extensive varicose veins which had been operated upon and large partially healed varicose vein ulcers of both legs. He was admitted for cataract surgery and the investigation revealed that his blood volume was excessive. RBC volume was 680 cc. excess and total blood volume was 492 cc. excess. After two phlebotomies and hydration, the patient went through with his cataract surgery and necessary recumbancy without vascular complications. This case is included to show the value of checking the blood elements prior to any surgery, especially when there is a suspicion of venous disease which might complicate the picture.

BIBLIOGRAPHY

1. Michel, J.: von Graefe's Arch. f. Ophth. 24:37, Part II, 1878.

2. Coats, : Royal London Ophth. Hosp. Rep. 16:62, 1904. ibid 16:516, 1906.

3. Verhoeff, F.: Ophth. Rev. 25:353, 1906. Arch. Ophth. 36:1, 1907.

4. Thomas, Cordier, Pierquin, Henry: Bull. Soc. d'ophth. de Paris, p. 72, November, December, 1946.

5. Johnson, C. C., and Baggenstoss, A. H.: Proc. Staff Meetings, Mayo Clinic, Vol. 24, pp. 628-636, 1949.

6. Stroebel, C. F., Hall, B. E., and Pease, G. L.: Evaluation of Radiophosphorus Therapy in Primary Polycythemia. J. A. M. A. Vol. 146, No. 14, pp. 1301-1307, December, 1951.

7. Klein, B.: Arch. Ophth. Vol. 29, pp. 699-710, 1943.

8. Kirby, D. B.: Arch. Ophth. Vol. 25, p. 883.

9. Moore, R. F.: Retinal Venous Thrombosis, a clinical study of 62 cases followed over many years. London. Geo. Pulman & Sons, Ltd., 1924.

INFECTIOUS HEPATITIS IN PREGNANCY

HOYT C. TAYLOR, M.D., *Meriden*

The Author. *Attending Obstetrician and Gynecologist, Meriden Hospital*

THE metamorphosis of acute yellow atrophy of pregnancy into pregnancy complicated by infectious hepatitis has occurred since the close of World War II. The impetus was provided by data acquired from the epidemics of infectious hepatitis during the past war and the realization by investigators Wood,[1] Mallory,[2] Zondek,[3] and Dill[4] that the sporadic and epidemic forms of infectious hepatitis have a common etiology, also that homologous serum jaundice is apparently identical pathologically. That the disease is caused by a virus is now definite. Havens[5] and Neefe[6] have produced the disease in human volunteers by a number of methods.

Up to 1947 acute yellow atrophy was still classified as a toxemia of pregnancy. In 1947 Zondek reported from Palestine an epidemic involving 29 cases in pregnancy. Prior to this, little data was available on the relationship of infectious hepatitis to acute yellow atrophy. Since this careful study Dill has reviewed the subject and has agreed with Zondek that so-called acute yellow atrophy of pregnancy is the severe form of infectious hepatitis as it affects pregnant women in the third trimester.

Dill reports after an exhaustive review of the literature that the disease in its severe form as it affects women in the third trimester of pregnancy is inevitably fatal. He states that only Ellison[7] has reported a nonfatal case. This view is probably too pessimistic but in view of the rarity of recovery it seems worthwhile to present our case of infectious hepatitis in the 8th month of pregnancy with recovery from hepatic coma.

CASE PRESENTATION

An 18 year old primigravida in her 8th month of pregnancy complained of discomfort in her right upper quadrant and weakness of two days duration. The antenatal course had been uneventful up to then. Weakness increased in the 24 hours preceding admission to the hospital for study. She also noted frequency of urination and slight swelling of her feet. On admission examination BP 110/70, abdomen distended by 8 months pregnancy, vertex presentation engaged deep in the pelvis, fetal heart good. The first impression was impending toxemia or early pyeloureteritis. Blood chemistry was ordered for the next morning and patient placed upon a toxemia regime. Vomiting occurred twice during the night but on morning rounds there were no additional findings. However, during that day patient became progressively drowsy and clinical jaundice appeared. NPN reported 52, blood sugar 54, and icteric index 31.5. The urine revealed trace of albumin and blood proteins were normal except for depression of the albumin fraction. Cephalin floc. 3 plus. (See Table I.) It was noted that the fetal heart had ceased. An infusion of 10 per cent glucose was started and Dr. Robert Healy called in consultation. He concurred in the diagnosis of acute yellow atrophy or infectious hepatitis as it is now known. Serum albumin (salt poor) was administered in 10 per cent glucose (50 Gms.). Methiscol and Berocca-C were started along with aureomycin intravenously.

During that night the patient although semicomatose became restless and it was noted that she was in active labor obscured by her near coma. She was moved to the delivery room with infusion running and given vitamin K intravenously and cross matched in preparation for delivery. Rupture of the membranes and low forceps were accomplished without the necessity of anesthesia. The fetus was macerated. Following delivery the placenta was expressed easily but contraction of the uterus was poor and a steady flow of blood which did not clot continued. The uterus was packed with oxidized cellulose (Hemopack) and a first degree laceration of the perineum repaired, all without anesthesia. Bleeding appeared under control but with no more than an estimated 300 c.c. of blood loss patient evidenced shock. BP 60/40. Treatment consisted of plasma 500 c.c., whole blood 1000 c.c. and continuous 10 per cent glucose. Blood pressure slowly recovered and by 24 hours after an additional 500 c.c. of blood and 500 c.c. of plasma, condition was equal to that before delivery. Urinary output remained good in spite of intensive intravenous therapy with blood. A cannula was kept open with 10 per cent glucose in water when other medications were not being administered by vein. Following delivery penicillin and dihydrostreptomycin were started in view of the possible contamination from the uterine packing.

On the 5th hospital day, the 2nd postpartum day, marked improvement was noted in the patient's general condition. She again became alert, professed hunger and was able to void when the retention catheter was removed. It was on this day that the urine first became positive for bile, a previously depressing finding from a prognostic standpoint.

Table 1

	6/27	6/28	6/29	6/30	7/2	7/5	7/23	8/7	9/12
Hb.	11.4	10.4		10.4	11.0				
RBC		3.9			3.92				
Icteric index	31.5	27							7
Hematocrit	34 vol. %		33 vol. %	37 vol. %					
Urine/Bile	Neg.		Neg.	Pos.					
Urine/Urobilinogen	Ft. trace		Ft. trace	Trace					
Ceph. Floc.	3 plus	3 plus					1 plus		1 plus
Cholesterol	94	78							
Chol. esters	46	44							
Per cent esters	49	56				38	72		
Total proteins	4.75		5.08			6.1	7.0		
Albumin	2.8					3.6	4.5		
Globulin	1.95					2.5	2.5		
CO_2		41.6	55.3	64.5					
Sugar	54		302	103					
NPN	52	50.5	50	45					
Chlorides		96.5	104						
Alk. Phosphatase		10.7				10	4.4		
Bilirubin		6.1		8.8		8.6	1.42	1.1	0.7

A low grade temperature regressed in the next three days and all antibiotics were discontinued. Recovery progressed except for the appearance on the 8th postpartum day of a typical Bell's palsy, right.

She was discharged after a total hospitalization of 13 days, still jaundiced, to be followed on a medical rest regime including strict bed rest at home.

LITERATURE

In view of the revolutionary changes necessary in changing our thinking of acute yellow atrophy as a toxemia of pregnancy to infectious hepatitis as a complication of pregnancy, it seems wise to review some of the material of Zondek and Dill's papers in some detail.

Zondek: In 12 of the 29 cases reported in pregnancy, definite contact was traced to mild non-pregnant cases, and some of those died from severe liver necrosis. The incubation period varied from 8 to 42 days. There was an incidence of 3 to 4 per cent in the population. Although generally benign, cases with a fatal outcome were observed almost exclusively in pregnant women. He noted that 18 out of 29 were definitely undernourished with regard to protein intake. All showed vitamin B deficiency. He noted several interesting laboratory findings, that in the severe cases there was a drop in urea blood level (high amino acids and high NPN), and although the blood cholesterol was usually decreased with depression of the ester fraction that, in two who died, there was no depression of cholesterol levels. In the 5 fatal cases he noted premature labor marked the onset of the terminal phase, that uterine contractions were relatively painless and labor relatively easy. In 2 cases severe uterine hemorrhage occurred when hepatic coma set in. This was controlled by tamponade only and was found to be not influenced by vitamin K or blood transfusion. Convulsions during coma were noted to resemble those of eclampsia. In postmortem examinations signs of regeneration of the liver could be recognized despite massive necrosis in the shrunken livers. In 4 cases that recovered the liver dullness was back to normal in 1 week. Recession of tachycardia was found to be a good sign.

Premature labor occurred in 7 cases, 5 ending fatally. A precomatose patient and a mild case at 7 months both recovered. Three of those patients who recovered became pregnant again and had uneventful courses. In 2 cases, chronic hepatitis developed. Babies born living or examined postmortem showed no evidence of the virus infection.

After observing this epidemic, Zondek feels that therapy should be directed along these lines: A. Diet consisting of high carbohydrates, high protein intake and protein supplements. B. Avoid operative intervention due to danger from hemorrhage, avoid general anaesthesia for its known detrimental effects on the liver and avoid active interruption of pregnancy. He feels that in the severe cases active interruption may aggravate the course while in the benign cases the fetus may be unnecessarily sacrificed.

It is interesting to note that there was no relationship between the severity of the clinical course and the depth of jaundice in these cases and that the prothrombin time was prolonged in only two cases and then only just before death. Both these cases bled just before death.

Dill presented a complete review of the literature and in addition to the observations of Zondek noted that the incidence in pregnancy in this country was anywhere from 1:2,000 to 1:10,000 cases. In a review of symptomatology he noted anorexia, fatigue, nausea and vomiting in the preicteric phase with jaundice occurring in the intermediate phase of the disease. Tenderness over the enlarged liver was usual. Elevation of the temperature was not striking, while elevation of pulse usually occurred late and along with coma and psychic instability were ominous signs.

He felt that therapy was ineffectual because the diagnosis was made late usually. Presenting 6 cases all ending fatally, he advocated "delivery as soon as possible in interest of both mother and child, if it can be done without altering maternal physiology unduly."

With regard to specific therapy, Farquhar et al[8] using aureomycin in hepatic disease coma noted phenomenal recovery in 2 cases of viral hepatitis in 2 children aged 6 and 10 and recovery from liver failure in a case of cirrhosis with marked improvement in another case of portal cirrhosis, who later became worse and died of cirrhosis. Post, Rose and Shore,[9] using human serum albumin as replacement therapy in the presence of a known defect in serum albumin synthesis found improvement in 21 out of 34 patients, all critically ill of progressive hepatic insufficiency who had failed to respond to the usual forms of therapy. Sixteen of the 34 were in hepatic coma when serum albumin was begun. Out of these, 9 recovered from their comatose episodes. They felt that salt poor human serum albumin had a definite place as a therapeutic adjunct in the management of severely decompensated hepatic patients.

Mickal[10] reporting from the Charity Hospital in New Orleans records 15 cases during pregnancy. Only 2 cases were comparable to our case and both exhibited premature labor and bleeding at the time of delivery or early puerperium and resulted in a rapidly fatal outcome in both cases.

Discussion: We may accept infectious hepatitis as a complication of pregnancy rather than a disease entity peculiar to pregnancy. Unless it affects the patient in the third trimester of pregnancy, the clinical course is usually benign. It is in the third trimester that infectious hepatitis may exhibit its severe form previously referred to as acute yellow atrophy. It is only in reference to this severe and usually fatal type that we direct our discussion. We were admittedly fortunate in hospitalizing our patient in the preicteric phase of her disease. Since the metabolic changes brought about by liver destruction seem to be responsible for the fatal outcome when it occcurs, our therapy was directed toward sustaining a balanced metabolic economy. This implied maintaining adequate blood glucose levels. It seems probable that hypoglycemia accounted for fetal death in this case. Serum albumin was administered in view of a known defect in albumin synthesis and likewise plasma and blood were used. Blood replacement after delivery was felt to be especially important. We were probably fortunate that bleeding was controlled by uterine tamponade in this case as it was in two cases presented by Zondek. In theory, bleeding in some cases may be only controlled by use of fibrogen solution as described by Reid[11] for it is apparently here that the defect in the clotting mechanism would occur through failure of fibrogen production by the liver. Although we did not utilize the prognosticating sign of a rise or fall in blood urea level, we were pessimistic when we noted absence of bile in the urine for to us it meant so badly a damaged liver that the bile formation function had been completely suspended. Return of bile in the urine coincided with improvement of the patient. All laboratory findings characteristic of liver damage, notably positive cephalin floculation, increased serum bilirubin, increased alkaline phosphatase, lowered blood proteins, confirmed severe liver disease except for the cholesterol and cholesterol ester percentage findings which as noted in two of Zondek's fatal cases were strangely not affected. Our only explanation is that the acutely critical stage of the illness came and passed so rapidly that there was not time for this metabolic change to take place.

Whereas the rational and purpose of therapy so far discussed were directed at maintaining the individual in physiologic and metabolic equilibrium, the use of aureomycin is based upon the known fact that the disease is a virus and that there is some evidence that a damaged liver may be further damaged by toxins liberated by bacteria of the large bowel. The

cases presented by Farquhar showed such remarkable improvement that it seems wise to give such seriously ill patients the benefit of this therapy although its efficacy is far from proved.

In the third trimester of pregnancy the onset of premature labor in a patient with infectious hepatitis and coma or a precomatose state may well be an ominous sign and bleeding during delivery or in the puerperium should be expected and should be treated vigorously by intrauterine tamponade or fibrogen infusions to be effective. Blood replacement cannot be over emphasized since a patient in such a precarious position metabolically may well react poorly to amounts of blood loss usually effectively handled by the normal uncomplicated patient. It was interesting for us to note that the case of Ellison reported by Dill to be the only case in the literature to recover, began to improve after blood replacement and that the only other therapy constantly given during her course was intravenous glucose. This patient also had a comparable sequella, a bilateral median nerve neuritis. This corresponds to the Bell's palsy which occurred in our patient.

Zondek found that the liver dullness returned in one week in four cases that recovered and Ellison's case passed a crisis on the 6th day; hence, it seems logical to point therapy in these cases to maintaining them in metabolic and physiological equilibrium and that if such can be successfully accomplished for a week that recovery may occur, for it was noted in fatal cases that although massive necrosis was present there were already signs of regeneration.

The problem of what to do in the acutely and desperately ill patient who is undelivered arises; whether to effect delivery or not. In our case as in others in the literature when massive necrosis of the liver took place, premature delivery of a dead fetus occurred. Any abdominal operative procedure to effect delivery is contraindicated for as in other instances of severe liver disease this usually results in a fatal outcome. Hence, if the disease is severe enough, the problem will solve itself, whereas if enough liver is left intact to maintain essential body metabolic processes, then there is nothing to gain by intervention. The conclusion reached by Zondek, namely, that even normal delivery is enough to tip the scales toward a fatality, could be explained on the basis that fetal death and premature labor are the results of such severe liver damage that death follows.

To conclude, it seems obvious that successful therapy must be predicated upon early diagnosis. Dill felt that failure here was responsible for the almost 100 per cent fatality rate. Once the diagnosis is made, efforts should be directed along the following lines: the broad concept being to keep the patient in metabolic and physiological balance for a period of a week which, from the literature, seems to be the critical period. This means continuous intravenous glucose, replacement of any protein deficiency either with salt poor serum albumin, plasma or blood.

Daily chemistry studies should be made to evaluate any variations that need correcting. For prognostication value the presence or absence of bile in the urine and the urea nitrogen level which was found of value by Zondek can be used.

So far as the pregnancy is concerned treatment should be directed toward the disease itself and should premature labor ensue, preparations should be made for blood replacement and control of bleeding in the 3rd stage of labor either by uterine tamponade with oxidized cellulose or infusion of fibrogen if available. Blood replacement should be immediate and adequate for such critical patients stand blood loss poorly.

The use of aureomycin seems indicated since it is directed against a known viral infection and because it has proved effective in the report of Post et al. Although its efficacy is far from proved, in view of the critical nature of the disease it seems wise to use it while awaiting further reports. Vitamin K and the usual vitamins known to be helpful in liver disease should be given routinely.

CONCLUSIONS

1. The metamorphosis of acute yellow atrophy of pregnancy into infectious hepatitis as a complication of pregnancy is reviewed.

2. A case of acute hepatitis with massive liver necrosis in the 8th month of pregnancy with recovery is presented.

3. A regime found effective in this case is outlined and recommended for further trial in such cases.

BIBLIOGRAPHY

1. Wood, D. A.: Archives of Pathology. 41:345, April 1946.
2. Mallory, T. B.: J. A. M. A. 134:655, June 1947.
3. Zondek, B., Bromberg, Y. M.: J. Mt. Sinai Hosp. 14: September-October 1947.
4. Dill, L. V.: Obs. & Gynec. Survey. 5:139, April 1950.

5. Havens, W. P.: Proc. Soc. Exp. Biol. & Med. 59:148, 1945.
6. Neefe, J. R.: Stokes, J., Gellis, S. S.: Am. J. Med. Sc. 210:561, 1945.
7. Ellison, E. T.: South. Med. J. 34:938, 1941.
8. Farquhar et al.: Am. J. Med. Sc. 220:116-172, 1950.
9. Post, J., Rose, J. V., Shore, S. M.: Archives of Int. Med. 87:775-788, June 1951.
10. Mickal, A.: Am. J. Obs. & Gyn. 62:409, August 1951.
11. Reid, D. E.: Trans. Internat. & 4th Am. Congress on Obs. & Gynec. Vol. 61 A:765, June 1951.

AN EVALUATION OF TELEPAQUE* A NEW CHOLECYSTOGRAPHIC MEDIUM

Robert M. Lowman, M.D., and Howard W. Stanley, M.D., *New Haven*

Since the first attempts to visualize the gall bladder radiographically, many different compounds have been investigated and of these several have been adopted for use. Each in turn has shown some improvement over the previous compound utilized for this purpose, either in better visualization of the gall bladder, in the reduction of untoward symptoms or in other factors.

One of the most recent compounds to be investigated, Telepaque, seemed to offer certain advantages over previously used contrast media. A series of comparison studies was undertaken to determine the effectiveness of this compound as related to another cholecystographic medium. It is not our purpose to present a statistical anaylsis since the number of cases reported by us is too small for this type of series. However, we feel that a sufficient number of examinations were performed to enable us to form an opinion as to the relative merits of the two compounds investigated.

Telepaque is a recently synthesized iodine-substituted organic compound containing 66.68 per cent iodine. On the other hand, Priodax, the compound compared with Telepaque, contains 51.38 per cent iodine. Chemically, alteration of the basic group of iodinated parahydroxy phenyl acetic acid was made in accomplishing the synthesis of telepaque. Since most observers agree that the hydrocarbon side chains which have been utilized in the synthesis of the various radiopaque compounds are non toxic in character, the alteration of the basic group is thought to be a reason for the diminished toxicity of Telepaque.

Christensen and Sosman[1] have set forth the requirements for a satisfactory cholecystographic medium as follows:

1. Selective localization with the gall bladder following oral administration.
2. Adequate roentgenographic visualization due to sufficient content of material of high atomic number.
3. A low level of systemic toxicity.
4. Absence of mucosal irritation.
5. Prompt, easy, non irritating elimination.

We feel an additional requirement should be added; that the administered dye produce no interference with the physiologic function of the gall bladder.

Collected figures by Christensen and Sosman[1] from published series of cases following the use of priodax indicated that forty-five to ninety per cent of patients showed undesirable side reactions. While priodax produced a satisfactory visualization of the gall bladder in most patients, numerous patients complained of nausea, vomiting and diarrhea. Both male and female patients complained of dysuria following its use. Rare reactions of major severity following administration of priodax have been recorded.

The preliminary studies of Telepaque included laboratory investigation of the hepatic functions following the oral administration of four Gm. of the media made in ten normal individuals before and approximately twelve hours following the ingestion of the drug. Studies were also completed one week following the ingestion of the drug in five patients. These studies included the icterus index, blood cholesterol values, VandenBergh tests, determinations of the phosphorous and alkaline phosphatase and thymol turbidity were done. No significant changes in the laboratory studies were demonstrated following the use of Telepaque.

One phase of our investigation involved the comparison of the symptomatology in patients given Telepaque with those same patients given Priodax at a later date. Seventy-five patients were observed by

From the department of Radiology, The Grace Unit of The Grace-New Haven Community Hospital, New Haven, Conn.
*Winthrop-Stearns, Inc.

this method. A second group of twenty-five patients were studied utilizing Priodax first. Each patient was given six tablets (three Gm.) of Telepaque or six tablets (three Gm.) of Priodax, twelve to fourteen hours prior to the scheduled time of examinations.

The second phase of the investigation involved a comparison of the diagnostic results in the same groups of patients. The following procedure was used in carrying out the examination: The patient was specifically cautioned to avoid fatty foods at the evening meal prior to the examination and to report for studies without breakfast. One tablet every five minutes was given, beginning at 8:00 P. M. Upon arrival in the x-ray department the following morning, three films were completed: A prone 14 x 17 film, a 10 x 12 oblique and an erect posteroanterior 10 x 12. Other positions, as well as fluoroscopy were occasionally utilized. After preliminary wet film viewing a fatty meal was administered and films were then completed to evaluate the evacuation phase of the vesicle.

Comparison of our results in so far as symptomotology associated with side reactions and diagnostic findings are similar to those of Christensen and Sosman[1] and Whitehouse and Martin[2] who have also completed preliminary studies of this new medium. The percentage of symptom-free patients was:

1. Christensen and Sosman—78 per cent.
2. Whitehouse and Martin—62 per cent.
3. Lowman, Stanley et al—58 per cent.

The comparative findings in our one hundred cases listing the symtoms are shown in Table 1. It is quite obvious from this table that a greater number of symptom-free patients were encountered following the use of Telepaque. The incidence and intensity of dysuria were definitely reduced. The one patient who complained of severe burning on urination with Telepaque complained of very severe burning when studied with Priodax. On the other hand, the intensity of the diarrhea in one patient was more severe following the use of Telepaque; although the diarrhea was present following the use of both cholecystographic media. The various other symptoms encountered can be seen in the accompanying table. Some reduction in the incidence of nausea and vomiting with Priordax could be obtained by administering the dye tablets after they had been pulverized in gelatin capsules, but this did not reduce the incidence of dysuria or diarrhea. In general the

Table 1

A COMPARISON OF THE INCIDENCE OF SYMPTOMS ASSOCIATED WITH THE ADMINISTRATION OF CHOLECYSTOGRAPHIC MEDIA

100 Cases—Studied with priodax and Telepaque

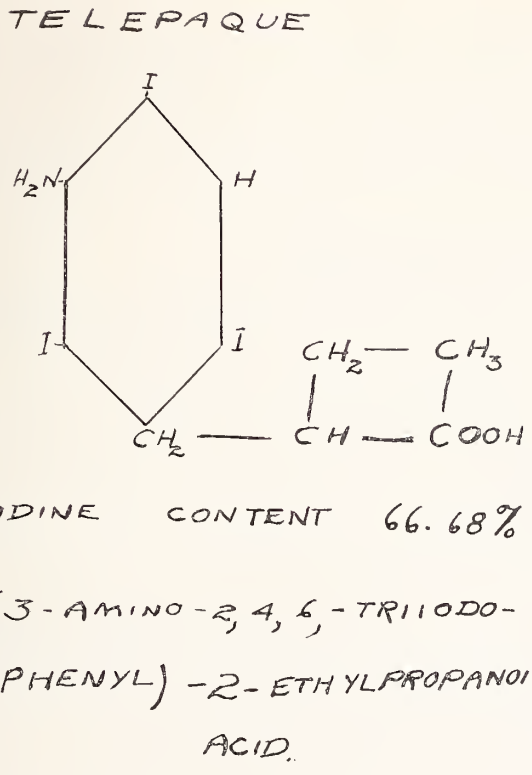
100 CASES		"P" PRIODAX 4-6 GM.	"T" TELEPAQUE 3 GM.
No. Symptoms		33%	58%
Symptoms		67%	42%
Nausea	mild	15	12
	severe	3	1
Vomiting	mild	4	2
	severe	1	1
Dysuria	mild	21	10
	severe	5	1
Others	mild	2	2
(pain, headache, insominia)	severe	1	0

symptoms remained more severe than in those patients who were given Telepaque.

The other phase of the investigation, namely the comparison of the diagnostic value of the two media showed the density of the shadow of the gall bladder to be definitely greater following the administration of Telepaque. Whitehouse and Martin[2] have reported that Telepaque may obscure opaque calculi because of the intensity of the gall bladder shadow. These authors noted a case in which opaque calculi which were visualized on the routine films were obscured following the use of Telepaque, and subsequently these calculi were better visualized when Priodax was employed. This has not been encountered in our series.

Six cases were noted which were considered as very poorly functioning gall bladders without stones, following the administration of Priodax. The six cases later showed very adequate and satisfactory concentration of dye with Telepaque. A total group of eleven cases in the Telepaque series was reported as non functioning. Twenty-one cases demonstrated an improved visualization of calculi with Telepaque. No cases were encountered in which the calculi were obscured by the Telepaque and which were subsequently demonstrated with Priodax.

An additional important factor in the studies performed with Telepaque was the increased incidence of the visualization of ductal shadows following the administration of the fatty meal. This visualization had become uncommon with the use of priodax. Because some observers have believed that the emptying time of the gall bladder with Priodax



studies, was prolonged, little emphasis was directed to the emptying time and the contraction phase of the gall bladder. We consider this phase to be important in the study of small stones. Occasionally films made during the emptying phase of the gall bladder after partial evacuation of the vesicle may demonstrate calculi not adequately seen or even missed in the preliminary studies.

Visualization of a normal cystic and common duct provides valuable confirmation of normal function of the gall bladder and the sphincter of Oddi.

Our present experience with Telepaque has prompted a return to the routine previously proposed by Sussman.[3] With this technique filming of the gall bladder was begun fifteen minutes following the ingestion of the fatty meal. In the Telepaque filled gall bladder, the fatty meal usually produced a prompt and adequate reduction of the gall bladder shadow.

This aided in the study of the contraction phase and resulted in a high percentage of visualization of the cystic and common ducts. These were demonstrated in twenty-nine cases. It is possible that more ductal shadows could have been demonstrated, but in the early part of the investigation, films were taken one hour following the fatty meal. Proportionally more ductal shadows were demonstrated in the group of cases in which film studies were begun fifteen or thirty minutes following ingestion of the fatty meal.

In ninety-six cases of the Telepaque group, the administration of the dye was associated with residual radiopaque material contained in the large bowel. This necessitated additional filming procedures in four cases in order to adequately evaluate the gall bladder. Priodax has not resulted in this type of difficulty. At times with Telepaque, this may be severe enough to require repeat examination using a smaller amount of the cholecystographic media.

SUMMARY

In summary, the frequent occurrence of residual radiopaque dye in the large bowel seems to us of minor importance. Telepaque offers definite advanatges as a cholecystographic medium.

1. It produces adequate roentgenographic visualization of the gall bladder in many cases where another compound failed to do so.

2. It aids in improved visualization of calculi.

3. It produces fewer and less severe symptoms.

4. It does not adversely affect the physiologic response of the gall bladder to a fatty meal.

5. It offers frequent visualization of the duct system.

ADDENDUM

Since the presentation of this preliminary report for publication more than 350 additional cases have been studied. Successful techniques for the visualization of the cystic and common ducts in more than 50 per cent have been devised. Preoperative cholangiography is thus made possible. Cases of hepatic duct visualization have been encountered. The results of the studies in patients with jaundice, the effects of various drugs and various types of fatty meals will be published in a subsequent separate paper.

BIBLIOGRAPHY

1. Christensen, W. R. and Sosman, M. C.: A Preliminary report on Telepaque, A New Cholecystographic Medium. American Journal of Roentgenology and Radium Therapy, November 1951, Vol. 66, No. 5.

2. Whitehouse, W. and Martin, O.: A comparative Clinical Study of Two Cholecystographic Media. Scientific Exhibit. 37th Annual Meeting Radiological Society of North America.

3. Sussman, M.: Emptying of the Normal Gall Bladder. American Journal of Roentgenology & Radium Therapy, 1937, 38:876-871.

GROUP PRACTICE OF ANESTHESIA

Mario L. Garofalo, m.d., Pierino F. D'Elia, m.d., Norton A. Kazanjian, m.d., Leopold M. Trifari, m.d., and Ulysses V. Golia, m.d., *New Haven*

At the present time there is widespread insecurity and instability in the practice of our specialty. The basic problem is to render the quality of service that the surgeon expects and that the patient deserves, at a fee that is reasonable to the patient and adequate for the anesthesiologist. It is the purpose of this paper to relate experiences with group practice on a private fee basis in the hope that others may profit by our experiences.

After a study of the exhibit by Dr. H. O. Brown entitled, "Types of Practice and Methods of Compensation" at the Third New York Postgraduate Assembly in December, 1949, we concluded that group practice on a private fee basis was the solution to our problem. We presented the idea of group practice to the director, the chief of staff, the governing board and the medical and surgical staffs of our hospital and received their approval. By June 1, 1950, we started our new practice.

OUR HOSPITAL

The Hospital of St. Raphael has a 430 bed capacity. There are eleven operating rooms, which include two cystoscopy rooms and one plaster room. There are three delivery rooms and one emergency room. In our hospital, the simultaneous use of more than eight operating rooms and one delivery room occurs infrequently. From June 1, 1950 to June 1, 1951 there were 8,134 anesthetic procedures administered by our department to surgical and obstetrical patients. Of these cases, 7,153 or 88 per cent were private, the remainder being hospital service cases, also covered by the group.

It is important to know the number of cases requiring anesthesia service as well as the number of active operating rooms in order to be able to establish the number of members in a department. It is also important to know the number of private cases in order to establish a fee schedule which will bring sufficient income to adequately support a department.

OUR ANESTHESIA ORGANIZATION

Our group consists of five anesthesiologists. Three of them are diplomates of the American Board of Anesthesiology; one has successfully passed the written part of the examinations and the fifth is eligible for certification. In addition to our group, we have one resident in anesthesia and four anesthesia nurses who have been adequately trained and are carefully supervised. The ratio of anesthesiologists to resident and anesthesia nurses is one to one. We feel that this ratio makes for a well balanced group because an all-anesthesiologist department would not permit a reasonable fee schedule to the patient and a higher ratio, e.g., one to two, would diminish the quality of anesthesia service.

Night calls are rotated among the group so that each member spends one night on duty at the hospital. Thus, an anesthesiologist is available twenty-four hours each day. A second anesthesiologist is on call at all times from home. The anesthesia nurses rotate call up to 11 p. m. from Monday through Friday. They are not on duty on weekends or holidays.

In addition to the members of the anesthesia department, our organization consists of an attorney, a certified public accountant, two secretaries and an anesthesia nurse's aide.

OUR FEE SCHEDULE

In April, 1950 we presented for approval several types of fee schedules to our surgical staff. Much of our information was derived from the monograph: "A Survey of the Practice of Medical Anesthesia in the United States," which was prepared by the

Presented at the meeting of the Connecticut State Society of Anesthesiology, November 20, 1951
From the Department of Anesthesiology, Hospital of St. Raphael

American Society of Anesthesiologists in 1950. According to the survey, the four factors most frequently used in determining a fee schedule are: (1) time, (2) patient's ability to pay, (3) difficulty of technique and (4) surgeon's fee. Other factors are: type of operation, patient's accommodation and risk involved.

The relative frequency of methods now in use are:

1. Combination of above factors	64.41 per cent
2. Time basis alone	29.83 per cent
3. Percentage of surgeon's fee	5.76 per cent
	100.00 per cent

It is interesting to note that the lowest fees exist in the New England section. The survey also revealed that about 75 per cent of anesthesiologists in the United States are in private practice and are remunerated on a fee-for-service basis.

Our staff selected a fee schedule based on specific operative procedure because it enabled the surgeon to quote our fee to his patient before entering the hospital. It was generally held that a schedule based on the time factor was unsatisfactory. We selected forty-six specific operative procedures and a fee range was set for each procedure. We advocate a fee range in preference to a fixed fee in order to provide some compensation for the difficulties that may be encountered in a specific case.

OUR CONTRACT WITH THE HOSPITAL

In May, 1950, a proposed draft of a contract was drawn up between the group and the hospital.

The group's obligations are as follows:

1. To assume full responsibility for the maintenance and supervision of the anesthesia department.

2. To provide full and adequate anesthesia services for surgery and obstetrics on a twenty-four hour basis.

3. To have a member of the group on duty at the hospital at all times.

4. To engage and employ anesthesia nurses, residents in anesthesia and other persons as deemed necessary for the efficient operation of the department at no expense to the hospital.

5. To assign members of the department to all scheduled cases with due regard for the nature of the case and respecting, insofar as possible, the preferred anesthesia of the attending surgeon.

6. To devote its services to and actively cooperate in the educational program of the hospital.

7. To set fees for service rendered to patients which are reasonable, fair and equitable without any obligation or expense to the hospital.

8. To provide anesthesia to service cases at no charge or cost to the hospital or patient.

9. To pay a monthly sum to the hospital for the use of facilities provided by the hospital including the cost of meals provided the members of the group.

The hospital's obligations are as follows:

1. To provide and furnish the group with adequate and sufficient amounts of materials and supplies.

2. To provide the group with adequate and necessary apparatus and equipment.

3. To charge all patients for any type of anesthesia a reasonable "materials fee" for use of hospital equipment, materials and supplies, to be collected by the hospital as its own separate income, this charge for "materials fee" to be included in the operating room charge in order to avoid any misunderstanding or confusion regarding separate charges made by the group for services rendered the patient.

OUR PARTNERSHIP AGREEMENT

On June 1, 1950, a partnership agreement was drawn up embodying the following terms:

1. The members of the group to become associated as partners for the purpose of engaging in the group practice of anesthesiology on a private fee basis.

2. The partnership to be known as "Dr. Mario L. Garofalo and Associates."

3. The partnership to appoint its senior member as chief whose decisions on all matters will be final.

4. Each partner to do his utmost to promote the welfare of the partnership.

5. Each partner entitled to full information on all matters pertaining to the partnership.

6. Each partner to contribute to the partnership an equal sum of money necessary to meet the initial expenses of the partnership.

7. The partnership to maintain a bank account for depositing income and paying expenses.

8. The partnership to engage a certified public accountant.

9. A semi-annual and annual accounting to be made each year.

10. Each partner to withdraw as compensation an agreed fixed monthly amount which is based on

length of service and professional qualifications.

11. Each partner to share in gains or losses equally.

12. Each partner entitled to one month's vacation, one month for illness with no loss of income and one professional trip with expenses paid and included in the vacation.

13. Each partner to protect the partnership against liability for private debts of partners.

14. Coverage for disability due to sickness or accident up to one year is provided by definite health and basic accident policies.

15. The partnership to provide and pay for other insurances: namely,

a. Life insurance for each partner.

b. Comprehensive liability including body injury and property damage.

c. Standard Workman's Compensation and Employer's Liability Policy.

d. Automobile liability and material damage policy.

e. Office burglary and robbery policy.

f. Fidelity individual bond.

16. Termination of membership in partnership results from the following:

a. Disability or illness continuing for one year with final accounting at end of said year.

b. Death with final accounting to partner's estate in three months.

c. Resignation upon giving six months' notice to partnership.

d. Misconduct or malfeasance with immediate dismissal and final accounting as soon as possible.

The partnership agreement was prepared by our attorney after reviewing the data from Dr. H. O. Brown and the monograph "Partnership Agreements" prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association. This was done in order to assure conformity with the established policies of our medical colleagues.

ADVANTAGES OF GROUP PRACTICE

A. To the surgical and obstetrical patient.

The quality of anesthesia service to all surgical and obstetrical patients is uniformly maintained at a high level for the entire twenty-four hours of each day. Our system of having an anesthesiologist on night call at the hospital has enabled us to give better care to all obstetrical and emergency cases. This is a distinct advantage to the patient. Preoperative rounds are made to evaluate the patient for premedication and selection of anesthetic agent and technique and to answer any direct questions concerning his anesthesia.

B. To the hospital.

The director of the hospital is relieved of all the responsibility of maintaining a department of anesthesia which is assumed by the group at no expense to the hospital. The hospital is benefited by having a more stable type of department. Group practice permits more active participation in the educational program of the hospital.

C. To the surgeon and obstetrician.

The surgeon and obstetrician can feel assured of receiving prompt and competent anesthesia service on a twenty-four hour basis and thus be relieved of the responsibility of selecting the agent and technique best suited for the patient.

D. To the group member.

1. There is a sharing of effort and responsibility with the clinical work apportioned as evenly as possible. In addition, each member is assigned special duties for which he is best qualified. These include care of the following items: equipment and supplies, drugs, administrative affairs, educational program and records.

2. Group pratcice allows for a well rounded postgraduate teaching program within the department. We have a schedule of weekly seminars covering all phases of anesthesia and each member is required to cover some aspect of the teaching. Resident training includes in addition to attendance at seminars, weekly basic lectures and personal direct supervision on service cases. The anesthesia nurses also receive separate weekly lectures as well as personal supervision of cases. In order to keep abreast of the latest literature, the group maintains a library on anesthesia and related subjects and, in addition, is compiling a reprint library with regularly scheduled journal club meetings.

3. Group practice gives a member a greater feeling of economic security. His earnings are fair and equitable and are commensurate with the length of time he has been in the practice of anesthesiology after completion of an approved residency. A new member just completing a residency starts out with a basic income. If, at the end of one year, he is satisfied with the group and is, in turn, acceptable to the

group, he is given a bonus for that year and becomes a junior partner. Then his earnings are increased yearly and, at the end of the third year, he becomes a full member of the group. He is required to become a diplomate of the American Board of Anesthesiology before he can realize his maximum earning.

4. As provided in our partnership agreement, health and accident insurance is maintained for a member's income up to one year in case of extended illness. Provision is also made, through life insurance, for income to the beneficiary in case of death of a member. There is also provision for liability insurance.

5. Group practice allows for adequate coverage when one member is absent through illness, vacation or professional trip. The member suffers no loss of income during his absence. Group practice also allows a member complete freedom of all professional duties during his leisure time.

PUBLIC AND PROFESSIONAL RELATIONS

A. Relation with staff.

The surgical and obstetrical staffs reacted most favorably to our proposal for establishing a group practice in anesthesia as the solution to our mutual problems. Without their fullest cooperation our group could not succeed. This cooperation has been manifest from the beginning and has resulted in our mutual gratification, especially on the part of the obstetricians. In supporting our plan for group practice on a private fee basis the staff is contributing toward discouraging outside agencies in gaining control of all branches of medical practice.

B. Relation with the patient.

The patient is first made aware of private group practice in the physician's office. His cooperation in educating the patient to the idea of group practice has proved highly beneficial in adjusting the patient to our new type of service.

Our direct method in educating the patient is accomplished through the use of printed material. We distribute to each patient a pamphlet entitled, "About Our Anesthesia Service," modelled after the one used by Dr. R. J. Whitacre. The pamphlet reaches the patient in one of three ways. On admission to the hospital the patient receives a copy from the admitting officer. In our preoperative rounds, in addition to informing the patient directly, we present him with a pamphlet if he has not already received one. On billing the patient we enclose a pamphlet with the first bill.

At the outset we experienced some difficulties with patients who were not fully informed about the change in anesthesia from a hospital service to a medical service on a private fee basis. However, with the cooperation of our colleagues and distribution of our pamphlets, patients accepted this change with only nominal protest. Patients, in many cases, recognized the distinct advantages of our services by sending us many letters of commendation.

C. Relations with Blue Cross.

Initially we received many complaints from patients who had Blue Cross contracts. Such patients were advised by us that Blue Cross pays for hospital service only. Since we are not in the employ of the hospital, anesthesia is rendered on a private fee basis and as such is not covered by Blue Cross. We advised all patients that our services are rendered on a basis similar to that of their physicians and surgeons. We further explained that our type of practice has made possible a quality of service which heretofore had not been attained under a salaried arrangement.

Blue Cross advised its members that Blue Cross would pay our fee if it were part of the hospital bill. The position taken by Blue Cross only served to create confusion and mislead the patient because, in truth, the hospital could no longer include our bill for anesthesia services as part of its hospital service. Since Blue Cross, by law, is limited to payment of only hospital services, it should be emphasized that its contract does not cover the payment of anesthesia when rendered as a medical service. Blue Cross is principally concerned with maintaining anesthesia as a hospital service and is not concerned with our problem of improving the quality of anesthesia service. We feel justified in advocating the private practice of our specialty and we recommend that attempts by outside agencies to hinder this purpose should be vigorously opposed.

OUR FUTURE

A. The situation today in anesthesia is highly confusing. Confusion exists not only with the public but also with the medical profession as a whole. It is high time that we in our own society find a solution before the situation becomes irreversible.

B. The reasons for the present confusion are obvious:

1. Our practice is confined primarily to the hospital and this creates the impression that anesthesia is a hospital service.

2. Nurses administer anesthetics and many feel it is not a medical service. There is no reason why an anesthesiologist cannot have an anesthesia nurse assist him provided she has had the proper training, is adequately supervised and is paid by him similar to the practice employed by other physicians.

3. Lack of uniform practice among our anesthesiologists—some are on a salary basis with the hospital either by necessity or by choice, whereas others are on a private fee basis.

4. Blue Cross covers anesthesia only when the anesthetic is rendered by a person in the employ of the hospital and the charge of administration appears in the hospital bill.

C. We offer three steps to the solution:

1. The first and most important step to the solution of the problem is to establish a uniform type of practice throughout the State of Connecticut. Such practice should be on a private fee basis.

a. The Statement of Policy prepared by the American Society of Anesthesiologists in April, 1950 advocates that hospital service contracts should provide for hospital services only.

b. In January, 1951 the members of the Connecticut State Society of Anesthesiologists unanimously passed a motion stating that they would be prepared to issue their own bills for anesthesia services between August 1 and October 1, 1951. Later, this date was extended to January, 1952.

c. In May, 1951 the House of Delegates of the Connecticut State Medical Society adopted the resolution of the Hartford County Medical Association stating that the benefits for the administration of anesthesia be eliminated from all hospital service contracts and be considered in the same manner as benefits for other medical services.

d. If Blue Cross continues to cover anesthesia, anesthesia service will be considered, in time, as a hospital service by "custom and usage." For this reason alone, the sooner we all go private, the more stable our specialty will be. The longer we delay, the more firmly will the policy of Blue Cross serve as an obstacle to our advancement and progress.

e. In March, 1950 the American Hospital Association issued a Statement of Policy in which it was resolved that anesthesia be included in a patient-day of hospital care and that services rendered by physicians be included in prepayment hospital service plans. Its position, in this respect, is at direct variance with the Statement of Policy of the American Society of Anesthesiologists which states, "Hospital services shall not include the administration of anesthesia by a physician which has been defined by the American Medical Association as the practice of medicine."

f. One should also note that Blue Cross plans are coordinated by the Blue Cross Commission of the American Hospital Association.

g. The American Society of Anesthesiologists' Survey reveals: "About 75 per cent of anesthesiologists in the United States are in private practice and are remunerated on a fee-for-service basis."

h. We should take heed of Dr. Tovell's[1] statement made at the American Medical Association convention in Atlantic City on June 7, 1949:

"More and more anesthesologists are willing and anxious to emulate the example of their medical and surgical confreres by engaging in private practice. The trend is an excellent one that should be fostered: otherwise the thin edge of the wedge of institutionalized and ultimately socialized medicine will be driven deep enough to open a crevasse into which surgeons, obstetricians and internists will fall. The anesthesiologists will be at the bottom to break the fall, but it is doubtful whether our usual efforts at pain relief will be rendered wholeheartedly. Why not face the fact that Blue Cross plans providing medical coverage can and will stall medical progress with devastating effect if payment is made only to hospitals for services rendered by employees?"

These remarks should make us all aware of the urgency in adopting a uniformity of practice that will best serve our interests.

2. If we succeed in establishing private practice throughout Connecticut, the second step is to give serious consideration in preparing a fee schedule which is fair, reasonable and equitable to the patient.

a. Our society has been negotiating with Connecticut Medical Service officials since 1948 in an attempt to formulate such a fee schedule. At our last meeting on November 13, 1951, we were bluntly told that Connecticut Medical Service could not extend its benefits to anesthesia if our Society was divided between salary and private practice. Such a division presents a challenge to our future security. Unless

we all adopt private practice, our demands will not receive favorable consideration from Connecticut Medical Service. Even with continued refusal by Connecticut Medical Service to extend coverage for anesthesia, uniformity of practice by the members of our specialty will result in encouraging commercial insurance companies to extend the provisions of their disability insurance policies to include the payment of anesthesia as a medical service.

b. The Survey of the American Society of Anesthesiologists further reveals that the lowest average fees for anesthesia services in the country exist in our own New England section. We should firmly strive to adopt a policy which will raise our professional income to an equitable level.

3. The third step is the establishment of good public relations. Patients want the best in anesthesia service as they want the best in other fields of medicine. This desire of the patient can only be secured through private anesthesia rendered at a fee within the means of all. The public should be fully informed of the import of having anesthesia services covered by prepaid medical insurance plans rather than prepaid hospital service plans.

SUMMARY

1. The basic problem is to render the quality of anesthesia that the patient deserves and expects of us.

2. We can attain this quality of anesthesia by engaging in some type of private practice.

3. Certain agencies, such as Blue Cross and the American Hospital Association, are adverse to private anesthesia.

4. This threat to private anesthesia is a problem that vitally concerns every anesthesiologist and every resident in anesthesiology and our future stability depends upon a solution of this problem.

5. In conclusion, let us put our own house in good order before outside influences force us to a position wherein the patient and our professional standing suffer complete deterioration.

Acknowledgment: We owe the deepest appreciation to Sr. Rose Alexis, director of the Hospital of St. Raphael, whose sincere cooperation and guidance made possible the evolution to group practice at our hospital.

REFERENCE

1. Tovell, R. M., and Steven, R. J. M.: Anesthesia and the Role of Anesthesiologists of Today, J. A. M. A. 141:8-13 (September 3) 1949.

ADDRESS OF ALFRED V. BODINE

President, Connecticut Manufacturers Association

Given at the Achievement Award Meeting of CMS, New Haven, May 15, 1952

It is indeed a distinct pleasure for me to address your Achievement Award Meeting in recognition of the enrollment of the 500,000th member in your Blue Shield organization in Connecticut, and the 23,000,000th member in these United States, which fortunately happens to be a Connecticut citizen. Nothing succeeds like success and the Manufacturers Association of Connecticut congratulates the Connecticut Medical Service, Inc., on its magnificent record of achievement.

Connecticut, the Constitution State, has set the pattern for many of our outstanding contributions to society in these United States. It is the initiative and energy of its God-loving citizens that makes this state the envy of the Nation. We are, of course, an industrial state primarily. We are also an insurance state, but above all this, Connecticut, with its rocks and rills, its woods and templed hills, and the splendid people who inhabit it, make it, to my mind, the garden spot of all the earth.

Victor Hugo once said "the most powerful thing in the world is an idea whose time has come." It may be a fifteen year old boy down on a New Orleans dock, seeing slavery for the first time, and saying to his father, "When I hit that thing, I'll hit it hard," and fifty years later he sits in the White House, signing the Emancipation Proclamation and all humanity is lifted up to a new level.

It may be a middle aged, half-paralyzed French doctor who hobbles out in the street, during the storming of the town by the Germans, to be stoned by his neighbors because they see him as a useless

mouth to feed, who goes back to his modest kitchen with blood and tears on his cheeks saying to his wife, "They want me to leave town, but I'm going to stay because I have something to give France that no man with a sword can give." And 27 years ago, when the French people chose the greatest Frenchman who ever lived, they didn't choose Napoleon. They chose this once persecuted man, Louis Pasteur, upon whose work modern medicine rests more than upon that of any other man in history.

This power of an idea may be the deep soul-stirring yearning which prompted the Pilgrims and Puritans to endure the cruel physical hardships of this once hostile country to enjoy, for the first time in their lives, an opportunity to be the builders of their own futures with the help of the Almighty, and minus the soul-shriveling scourge of a dictatorial government. And less than 175 years later that embryo of an idea bursts forth into a new nation dedicated to the proposition that "all men are created equal, and endowed by their Creator with certain inalienable rights—life, liberty, and the right to pursue happiness." To secure those God-given rights, says the Declaration of Independence, governments are instituted among men, deriving their just powers from the consent of the governed.

All these rights, please note, were endowed, not by Harry Truman, Joe Stalin, the Wage Stabilization Board, but by God, upon individual men. And the security of these rights, again please note, was the responsibility of our government whose just powers were not derived from Phil Murray, Walter Reuther or William Green, but from the consent of the governed—you and I and over 150 million more Americans, the majority of whom seem to be confused over this simple and original idea of the rightful role of government.

The early builders of our Republic were not confused. They, the farmers, the merchants, the lawyers and the mechanics, had faith in the power of an idea which they set down in the Declaration of Independence, the Constitution, and the Bill of Rights—a formula or blue print which they felt would outlast their lives and those of their immediate descendants. This solid but simple plan for human freedom was not built upon the fence-sitting type of academic freedom, free thought skepticism, or agnosticism, but rather upon basic truth.

Its power was soon to be manifest in Connecticut, for within 25 years after the Declaration of Independence had been signed and eleven years after the adoption of the Constitution, two men, John North and Eli Whitney, had developed the interchangeable parts system of manufacture which, during the past 150 years, has changed our civilization from the ox cart to the atomic age. Other men in Greece, France, and England had thought of the idea many years before, but lacked the freedom under their dictatorial governments to perfect it. With the incentive of freedom granted under the American blue print, Eli Whitney not only invented the cotton gin which speeded the development of the cotton textile industry, but also, through the discovery and development of the interchangeable parts system, laid the foundation upon which two Connecticut companies, Colt's Patent Firearms Co., and Pratt & Whitney Company (now known as Niles Bement-Pond Co.) developed our mass production system to an advanced state. And from these companies and others whose rapid growth was due to the lower cost production made possible by the interchangeable parts system, many mechanics went West to establish machine tool and other plants that have helped to skyrocket America's material future to a place of international leadership.

The power of this freedom "idea whose time had come" created such a ferment of inventive ideas in Connecticut that she has continued to lead all other states in the number of patents granted to her citizens. For many of these years, Connecticut inventors had more than twice as many patents granted to them as were given to inventors in any other state.

While Connecticut people did a splendid job with the comparatively few fertile acres available, and I might add they are still doing it, population growth forced a westward movement to new lands for the less inventive and accelerated manufacturing activity for those who remained. Thus fostered by the incentive of freedom to keep the fruits of their labors, and by the harsher edict of necessity, men continued to build the great brass and copper industries of the country in the rock infested Naugatuck Valley where not a pound of copper was available. They built the clocks and watches, the springs, the hat industry, the bearings industry, the foundations of the electrical, rubber, automobile and chemical industries and many others, too, in an area where all basic raw material had to be imported first by water, then by rail, and still later by rail, water, truck and plane.

It was no easy task to build this state from the

crude hand tool period of the Revolutionary War to the highly developed stage during World War I, when Connecticut was called the Arsenal of Democracy. It was even more difficult to continue to hold its leadership in war production per capita over those states nearer to material supply sources, through World War II and even to the present, especially when politics entered into the lowering of freight rates in favor of competitive states to the South and West. Now that tariff protection is being gradually lowered and freight rates increased still more, I predict that we shall be forced to use every last ounce of ingenuity we possess to keep pace with our competitive states in the years ahead.

And so tonight we do homage to yet another idea whose time has come, namely, the free and voluntary participation in a nation-wide insurance plan, designed to give a reasonable freedom from fear of hardship in periods of adversity.

It would be trite indeed for me to remind you that the early days of our pioneer forefathers were days of cruel hardships in many respects. And yet against this picture of long hours, of relentless toil, there comes to my mind the pictures of the families of these early pioneers, trudging their way to church on the Sabbath Day, the men carrying muskets to insure the safety and security of their families against the attack of unfriendly savages. I think in a measure this epitomizes the ideology that we respect here tonight. Some will say that our progress in social reform has been too laborious and slow. All things of course are relative, but Connecticut has in many of these fields again been the pioneer.

Our Workman's Compensation laws were among the first in the Nation, and they have always been among the best in the nation. In later years we have provided the so-called Old Age Insurance, Unemployment Compensation and on a purely voluntary basis, and in the interest of man's welfare, we have voluntary insurance plans for employees in industry and business, initiated under our so-called "free competitive enterprise system" and commonly called Group Insurance. All of us in this room can remember the day when Group Insurance first made its appearance in industry. Then that plan began to have its base broadened to include benefits other than death benefits. To include the members of the family of the employee, and various other benefits that were paid for in whole or in part by the employer, and finally we come into this magnificent Blue Cross organization and the Blue Shield as the surgical adjunct to it, all on a voluntary basis, organized and administered, not in the spirit of a profit organization, but for the mutual protection of happy homes in a free America.

We have come to speak of this type of protection as "off the job insurance" and I would like to give you the latest definite figures that are available as to the progress that "off the job insurance" has made in Connecticut on a free, voluntary basis. A survey was made in the latter part of 1950 and replies were received from 514 manufacturers in Connecticut representing a total employment of approximately 275,000 people. Of these 514 companies, 178 companies, representing a total employment of 246,127 people, furnished "off the job" cash sickness benefits. Since that time there has been a substantial increase in the number of employees covered but the next survey on this matter is scheduled for the latter part of this year, so that our statistics will be available for the 1953 session of the Legislature. These benefits generally ran for 13 weeks, although some ran from 13 to 26 weeks. The minimum and maximum amount varied quite considerably, with the minimum usually in the neighborhood of $25 a week and the maximum as high as $75 a week, or full pay in a few instances, although the amount usually ranged in the neighborhood of $25 a week.

When we consider that there are approximately 420,000 people employed in industry in Connecticut, that our Manufacturers Association represents approximately 375,000 of these industrially employed people, and that in 1950 approximately 250,000 of these people were already covered with a voluntary type of insurance, I think we stand pretty well in this matter of "off the job" insurance.

Now let us remember that these policies have not been available to small industries, but only to those employers with a specified minimum number of employees. In order to get down to the really small employer, or the entrepreneur, The Manufacturers Association undertook to make available to the very small companies, the same type of coverage as was available to the larger manufacturer. About one year ago, our Manufacturers Association of Connecticut, in conjunction with our insurance companies, worked out a plan whereby employers with as few as four employees, and a maximum of fifty employees, could provide weekly indemnity benefits under a Group Plan at reasonable rates and on favorable terms. About the time we were ready to offer this plan to our members, the Wage Stabilization

Board issued some bureaucratic rulings that held the plan in abeyance until its status could be clarified. On April 1 we were advised that our plan could be made effective under Wage Stabilization Board Rulings and hence it was immediately offered to our smaller members.

I have only the results of the first three weeks of this offering to our smaller employees, but up to April 21, 90 companies representing about 1,500 employees have already signed up for this insurance. It is being enthusiastically received and as rapidly as our members can be contacted, we are confident its acceptance will be greatly increased.

Again, I want to emphasize that this is on a purely voluntary basis and it keeps the State out of the insurance business while making this type of insurance available to practically all employers. Before you say to yourself, yes, but how about the employees in business and mercantile establishments, they are not in industry and therefore not eligible for this group coverage. We recognize that situation and have recommended to the insurance companies that a similar type of Group Policy be made available to these business organizations through such associations as local Chambers of Commerce, Boards of Trade, etc., so that the coverage will be available to as wide a segment of our population as possible.

I am convinced that this type of social benefit is best handled and best administered on a voluntary, or if you please, "free enterprise" basis. Blue Shield, Blue Cross, along with the insurance companies, are focused on the same broad program.

Now there are those groups in and out of government who believe this matter should be a compulsory matter enacted by government and administered by government. Personally, I am unalterably opposed to any compulsory plan of State administered off the job insurance. A survey of our governments, Federal and State, in the insurance field, will convince even a layman that the job can be done better with less administrative cost with greater flexibility, and with higher standards for judging efficiency under our competitive free enterprise and voluntary system.

All of us, as we go through life, ultimately strive for some goal. With the average American, it is mostly happy homes, respected positions in our communities, and a sense of security, or at least a reasonable freedom from fear.

Our errors in the past have been that we thought of those things as granted to us by our Constitution, Federal and State, and that they were already purchased for us by our sturdy and valiant forefathers, also that these things were a part of our rights as citizens, and that all we needed to do was to reach out for them as we would climb a tree and pick a ready-ripe tasty fruit. Many of us have already learned the fallacy of that philosophy.

But in the area of offering security to the individual or at least providing a reasonable freedom from fear, it should be accomplished not by diminishing the area in which the forces of free enterprise may work, but by harnessing the driving power of those forces, and I submit to you that in the programs that we have been discussing, we have demonstrated our ability to do that very thing. No more conclusive evidence should be needed in this area of social progress than the magnificent record already made on a voluntary free enterprise basis.

If we would keep our liberty and our freedoms, then we must be willing to fight for them. There will always be powerful groups preaching the philosophy that Government should do all these things for us. It is again a matter of eternal vigilance and it is my hope that as Connecticut has carried the torch in the past, she will continue to carry that torch for the preservation of free enterprise in America.

TWENTY-SEVENTH CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

New Haven Hospital and the Yale School of Medicine, New Haven

September 17, 18, 1952

The 1952 Clinical Congress will be concentrated in two days instead of the customary three days and all the meetings will be held at the New Haven Hospital and the Yale School of Medicine.

Three sessions will be held simultaneously in three different meeting places giving a broad selection of topics. Material in the field of general medicine and related subjects will be presented on Wednesday, September 17, and surgery and related subjects will be presented on Thursday, September 18.

Registration for members of the Society will be $3 and non members $4. Medical students, interns, and residents will be the guests of the Congress, if properly certified. Cafeteria luncheons will be served on both days by the New Haven Hospital.

WEDNESDAY, SEPTEMBER 17

MORNING SESSIONS

9:30 Registration

10:00 Diabetic Coma—Physiology and Treatment
Garfield G. Duncan, *Philadelphia*
Brady Auditorium,
Hugh L. Dwyer, *presiding*

New Drugs in the Treatment of Tuberculosis
Ralph Tompsett, *New York*
Gymnasium—Medical School,
Kirby S. Howlett, Jr., *presiding*

Causes of Sudden Death
Milton Helpern, *New York*
Farnam Amphitheater,
Walter Weissenborn, *presiding*

11:00 Gout
John H. Talbot, *Buffalo, N. Y.*
Brady Auditorium,
Hugh L. Dwyer, *presiding*

Medical Management of Hyperthyroidism
Earle M. Chapman, *Boston*
Farnam Amphitheater,
William T. Salter, *presiding*

Critique on Current Theories on the Pathogenesis of Arteriosclerosis
Frederick T. Hatch, *New York*
Gymnasium—Medical School,
Chester W. Fairlie, *presiding*

12:30 Luncheon—New Haven Hospital, Fifth Floor

WEDNESDAY, SEPTEMBER 17

AFTERNOON SESSIONS

2:00 Diagnosis and Treatment of Arthritis — Brady Auditorium,
Russell L. Cecil, *New York* — Gideon K. DeForest, *presiding*

Present Day Drug Therapy in Hypertension — Gymnasium—Medical School,
David Ayman, *Boston* — Arthur J. Geiger, *presiding*

Toxemias of Pregnancy — Farnam Amphitheater,
Leon C. Chesley, ph.d., *Jersey City* — Luther K. Musselman, *presiding*

3:30 Pediatric Seminar — Gymnasium—Medical School,
David H. Clement, *presiding*

Abdominal Pain in Infancy and Childhood
Orvar Swenson, *Boston*

Hypoplastic and Aplastic Anemias of Infancy and Childhood
Carl H. Smith, *New York*

Kidney Diseases in Children
Henry L. Barnett, *New York*

Progress Report on ACTH and Cortisone — Brady Auditorium,
Currier McEwen, *New York* — John C. Leonard, *presiding*

Clinical Application of Radio-Active Isotopes in Malignancy — Farnam Amphitheater,
Richard H. Chamberlain, *Philadelphia* — Arnold H. Janzen, *presiding*

Indications For and Contra Indications to Blood Transfusions — Fitkin Amphitheater,
Lamar Soutter, *Boston* — Ralph E. Kendall, *presiding*

7:00 p. m. Reception and Dinner for Vernon W. Lippard, Dean, Yale University School of Medicine; New Haven Country Club

Reservation cards for this dinner will be included with the program of the meeting which will be distributed to all members

THURSDAY, SEPTEMBER 18

MORNING SESSIONS

9:30 Registration

10:00 Surgery of the Hand — Brady Auditorium,
J. William Littler, *New York* — Paul W. Vestal, *presiding*

Management of Acute Head Injuries — Gymnasium—Medical School,
A. Price Heusner, *Boston* — William J. German, *presiding*

A Re-examination of the Treatment of Severe Burns — Farnam Amphitheater,
Francis D. Moore, *Boston* — Gervase J. Connor, *presiding*

THURSDAY, SEPTEMBER 18

11:00 Carcinoma of the Breast — Gymnasium—Medical School
Ernest M. Daland, *Boston* — N. William Wawro, *presiding*

Heart Surgery — Farnam Amphitheater
Dwight E. Harkin, *Boston* — Bliss B. Clark, *presiding*

Plastic Operations Upon Organs of the Genito-Urinary Tract
Oswald S. Lowsley, *New York* — Farnam Amphitheater
Thomas M. Feeney, *presiding*

12:30 Luncheon—New Haven Hospital, Fifth Floor

AFTERNOON SESSIONS

2:00 Surgical Treatment of Malignant Tumors of the Lung — Brady Auditorium
William F. Rienhoff, Jr., *Baltimore* — Gustaf E. Lindskog, *presiding*

Pitfalls in the Treatment of Fractures — Gymnasium—Medical School
Charles S. Neer, II, *New York* — Beckett H. Howorth, *presiding*

Medical Management of Peripheral Vascular Disease — Farnam Amphitheater
William T. Foley, *New York* — Paul Kunkel, *presiding*

Surgical Management of Peripheral Vascular Disease
Jere W. Lord, Jr., *New York*

3:30 Dynamic Therapeutics in Chronic Disease — Brady Auditorium
Henry H. Kessler, *Newark* — Thomas F. Hines, *presiding*

The Contributions of Endocrinology to Office Gynecology
Somers H. Sturgis, *Boston* — Gymnasium—Medical School
Joseph H. Howard, *presiding*

Surgery of the Gastro Intestinal and Biliary Tract — Farnam Amphitheater
Richard B. Cattell, *Boston* — Thacher W. Worthen, *presiding*

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMIS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Dean Vernon W. Lippard

The announcement of the appointment of Dr. Vernon W. Lippard as the new dean of the Yale School of Medicine is welcomed by his many friends in Connecticut as a fortunate choice and one which will forward the interests of the school in its important place in the medical affairs of the State and the Nation. Dr. Lippard who has been dean of two medical schools is highly qualified for his important and influential post. President Griswold in announcing his appointment said, "He is interested in and understands teaching as well as administrative work. His wide range of experience in both public and private universities stands him in good stead in an area of education which receives both public and private support, and to which continuing support of both kinds is essential."

Dr. Lippard comes as no stranger to the Connecticut scene. He graduated from Yale in 1926 and received his M.D. degree cum laude at the Yale School of Medicine in 1929. Following this he served an internship in the New Haven Hospital. Subsequently he was assistant resident and later resident pediatrician at the New York Nursery and Child's Hospital. In 1932-33 he was resident pediatrician at the New York Hospital and for the next five years an instructor in pediatrics at Cornell University Medical College. From 1942 through 1945 he served with the U. S. Army Medical Corps and at the time of his release from service he held the rank of Colonel and was Chief of Medical Personnel, Army of the Western Pacific.

Dr. Lippard comes to Yale from the University of Virginia where he has been dean of the Department of Medicine since 1949. Previous to this from 1946 to 1949 he was dean of the School of Medicine at Louisiana State University and earlier from 1939 to 1946, associate dean of the College of Physicians and Surgeons at Columbia University.

From the foregoing it is obvious that Dr. Lippard brings to his new position a fine experience in clinical and administrative medicine. Those who are acquainted with his record know that he has a wide interest in all problems pertaining to medical practice.

The Connecticut State Medical Society congratulates the University upon its choice of Dr. Lippard for dean of the School of Medicine and looks forward with pleasure to any cooperative effort in which it may serve with him and his colleagues toward our common goals.

Dr. John W. Cline

The address of the President, John W. Cline, before the House of Delegates in Chicago on June 9 which appears elsewhere, warrants careful reading. Dr. Cline's vigorous leadership in the AMA during the past two years has been one of high accomplishment during a time when organized medicine has had to face many new problems. He leaves a record which will be remembered as one of significance and worthy of emulation by those who will follow. His many Connecticut friends will be interested in the honor in which he is held in his own land as witnessed by the following editorial from *California Medicine*.

Culmination

Within another month Dr. John W. Cline of San Francisco will turn over the presidency of the American Medical Association to his successor. At that time he will be relieved of the many burdensome duties which have accompanied his two years as president-elect and then president of the world's largest medical organization.

As the time approaches for another AMA chief to take office, a review of Dr. Cline's activities is indicated, both for the lesson available to others and for the moral to be learned from a man who knew where he was going, how to get there and how to brings others along with him.

John Cline entered the official ranks of the American Medical Association only seven years ago, when he first became a Delegate from California. In his first few sessions of the AMA House of Delegates he encountered opposition, if not downright antagonism, to many of the subjects he broached in behalf of his fellow physicians in his home state. The California delegation in the AMA had not enjoyed too high a respect from some other sections of the country and when Dr. Cline and his fellow delegates came along with such unmentionable ideas as revising the top management force of the parent organization, they did little to increase their own popularity.

Perseverance, however, began to bear fruit as more and more members of the House of Delegates came to listen more attentively to the logic, the reason and the forcefulness of the proposals made by the Californians. Dr. Cline was in the forefront of this campaign, ever ready to speak with his well-ordered vigor, always willing to listen to the other fellow and to compose differences which did not conflict with the principles he and his associates held to be vital for the good of American medicine.

As the California ideas came to be more favorably accepted in the AMA House of Delegates, other changes took place. Some shifts in personnel, both at the policy-making and at the administrative level, brought forth a stronger organization, one more fully equipped to deal with the problems of the times. Dr. Cline remained at the head of this transformation, urging the positive and aggressive steps needed to create a better AMA. His exceptional ability to speak, undoubtedly stemming from his pre-medical debating team days, and his self-evident leadership, again going back to his collegiate experiences, stood him in excellent stead.

Dr. Cline has an ability to sway an audience which is not granted to many men. He is possessed of the innate capacity to grasp a situation, translate it into coherent and understandable terms and transmit it to those working with him. This faculty, from a standing start, impressed itself so indelibly on the minds of the delegates in the AMA that, without waiting for John Cline to go through subordinate offices, they unanimously elected him in 1950 as president-elect of the American Medical Association.

Once in that position, Dr. Cline continued to use well his administrative and persuasive talents. Without stint, without regard to the amount of time demanded of him, he set forth to carry the story of the new AMA to the country. Speaking engagements flooded in on him and, to his credit, he accepted them wherever it was humanly possible to do so. His travels in the past two years have taken him to Europe, to the islands of the Pacific, to military installations all over the country and in Europe, to lay audiences in public meetings and on radio programs, to debates, to forum sessions and, more important, to medical audiences in practically every state in the country.

In all of these places Dr. Cline has followed out his original theme of the good in American medicine, of the positive approach to matters of public interest, of the development of voluntary prepaid health insurance, of the strides made by medicine in an atmosphere of freedom and professional integrity. Certainly it does not in the least discredit the abilities of other advocates in the same field to say that undoubtedly John Cline has been the foremost proponent, the most effective, in carrying this story to the American people.

An example of his unstinting devotion to this duty can be gained from a review of just one of his travel itineraries last year. In a period of five weeks he went from San Francisco to Denver, Kansas City, St. Louis, Louisville, Memphis, Atlanta, Miami, Washington, Wilmington, New York, Portland, San Francisco, New York, New Haven, New York, San Francisco, Reno, Los Angeles, St. Louis, Pittsburgh, Chicago, Grand Rapids, Chicago, Denver, Rock Springs, Wyoming and thence back to San Francisco.

In carrying out other itineraries of comparable scope, and in spending more than two-thirds of his time away from his own professional office, John Cline has racked up a new record high mileage in

the history of United Air Lines. By the close of his term of office in the AMA he will have traveled more miles in one year than any other passenger in United's history. Next month he will have completed more than 125,000 miles of air travel in one year.

Next month John Cline will lay down his reins in the AMA. We know he will still be called upon by that body to lend his talents for the good of medicine, but he will be relieved of his multitudinous and arduous duties as the top elective officer. We will welcome him back to California, his birthplace and his home. We will welcome back in our own ranks his counsel, his capacity and his courage in his convictions. California will gain by his return.

California is proud of having contributed John Cline as a president of the American Medical Association, especially in the trying period in which he has served. For the good of medicine we hope that future AMA presidents will reach and, if they can, surpass the mark that he has left during his tenure. The goal is high but the accomplishments great.

New Drugs For Tuberculosis

Public announcement was made last February of two new antituberculosis drugs, viz., isonicotinic acid hydrazide (now called Isoniazid) and its isopropyl derivative. The enthusiastic publicity which followed is well known to every physician. Perhaps never before in history did claims, conclusions and conjectures as to the eventual effect of specific drugs upon the treatment and control of tuberculosis so far exceed known scientific facts. These facts have now been published.[1] They were reviewed in an editorial which appeared in the *Journal of the American Medical Association* dated March 22, 1952 and in a special article published in the May 1952 issue of the CONNECTICUT STATE MEDICAL JOURNAL.[2] Both journals strongly emphasized the need for far more information before the legitimate place of these new drugs in the treatment and control of tuberculosis can possibly be determined.

The medical profession takes pride in the healthy skepticism which characterizes its practitioners. This skepticism has repeatedly proved a major bulwark in the protection of patients and public against the premature and ill advised use of a new medical discovery. Yet recent incidents suggest that normal professional caution is finding it hard to resist the heavy pressures which publicity about these new drugs has generated.

In New York City the Department of Health itself is planning a program of home treatment with these drugs for patients unable to gain admission to tuberculosis sanatoria or hospitals. In Connecticut the Tuberculosis Commission is receiving letters from patients, declining admission to sanatoria and stating that arrangements have been made instead to receive treatment at home with the new drugs. There are many reasons for challenging the wisdom of launching a program of home treatment anywhere at the present time. But in New York City, where the number of beds for tuberculosis is far from adequate, the program may at least be rationalized on grounds of expediency. Also, such a program, under the auspices of one organization, can perhaps be justified as a clinical study. In Connecticut, where the deficit of sanatorium beds is small indeed compared to New York, the deliberate election of home treatment with these drugs by individual patients can be justified on neither of these grounds.

While the toxicity from prolonged administration of Isoniazid is still unknown, the principal objection to its widespread use is not from this source. Toxic effects to date have, with a few exceptions, been infrequent and mild. The principal objection rests upon the high probability that treatment at home with this drug or its isopropyl derivative alone will deny the patient the benefits of a really optimum therapeutic program when his tuberculosis is first discovered. This is the very time when an optimum program, especially designed to fit the case at hand, and based upon a free and unlimited choice from all the therapeutic resources now available, is most likely to lead to the lasting cure of his disease.

The fallacy in attempting convenient short cuts to this objective is well illustrated by the experience with other antituberculosis drugs. Of the drugs already subjected to adequate clinical trial, the combination of streptomycin and para aminosalicylic acid (PAS), administered concurrently, has demonstrated by far the strongest and most prolonged antituberculosis effect. In the vast majority of tuberculosis patients even this combination has proved totally inadequate to effect a cure until collateral therapy, appropriate to the case, is also called into play. Furthermore, sound integration of streptomycin and PAS with collateral therapy demands careful

planning for each case individually. Such planning requires the collaboration of physicians and surgeons familiar with tuberculosis and in a position to observe the patient closely and continuously from the clinical, roentgenographic, and bacteriological points of view and to obtain pulmonary function studies and other laboratory tests whenever these are needed.

Even in Connecticut many patients find it necessary to start treatment at home while awaiting a sanatorium bed. When chemotherapy is required, experience has shown that streptomycin and PAS, in combination, can usually be employed safely and without jeopardizing the eventual outcome of treatment, provided both drugs are administered continuously and uninterruptedly until the patient can be admitted to a sanatorium or hospital for the collateral therapy required. There is no such assurance when Isoniazid or its isopropyl derivative is employed instead.

Experience to date provides no evidence whatsoever that either of the new drugs is superior to the combination of streptomycin and PAS (or, for that matter, even to streptomycin alone) in its effect upon clinical tuberculosis in general. To be sure, marked symptomatic improvement has been reported in many patients who had previously received streptomycin and PAS and whose improvement on these drugs was unsatisfactory. But most of these patients were either known or may be presumed to have had infections refractory to streptomycin and PAS because of bacterial resistance to one or both drugs. They were the logical patients to choose for first tests with a new drug, and their improvement forms an important part of the evidence that the new drugs do, indeed, have a significant antituberculosis effect. This fact is widely accepted, and there is little doubt that the new drugs will find a place of importance in the treatment of streptomycin resistant tuberculous infections. But obviously this is far from meaning (as some have assumed) that the new drugs will be more effective than streptomycin and PAS in other patients, whose infecting bacteria are still sensitive to streptomycin and PAS, or who have not even been treated previously with any drug.

Actually the relative effectiveness of the isonicotinic acid derivatives as compared to streptomycin and PAS is not yet known. Nevertheless, certain preliminary observations suggest strongly that the old drugs may still be best. Data from the cooperative study by the Army, Navy and Veterans Administration[3] indicate that improvement by x-ray has been observed much less frequently in patients treated with Isoniazid for approximately two months than had previously been observed in another larger group of patients treated with streptomycin alone for the same length of time. Steenken and his associates at the Trudeau Sanatorium[4] have demonstrated the emergence of bacterial resistance to Isoniazid and to its isopropyl derivative in a high proportion of patients treated for from two to three months. In a Connecticut sanatorium where studies are in progress,[5] rapid elimination of tubercle bacilli from the sputum within two months has occurred, proportionately, three times more frequently in patients treated for the first time with streptomycin and PAS than in a small group of patients treated with the new drugs. It is on criteria such as these, not on mere improvement in symptoms, that the relative merits of antituberculosis drugs must eventually be decided. These adverse data are admittedly far too limited at this early stage to permit definitive conclusions. But they are certainly worthy of note at a time when the merits of Isoniazid are being heralded so loudly.

One thing, at least, seems evident. Isoniazid and its isopropyl derivative are, at best, unlikely to prove more than valuable adjuncts in the treatment of tuberculosis. There is clearly no reason to conclude that the need for careful integration with other forms of treatment will prove less frequent or less essential than has been the case with other antituberculosis drugs.

The sanatoria of Connecticut are well equipped and staffed to meet this need. The physicians of Connecticut have long followed the practice of sending tuberculous patients to sanatoria in all but exceptional circumstances. This practice is eminently sound, not only because it serves the best interests of patients, but also because it is the best possible means of eliminating a dangerous source of infection from the home and community. To alter this practice because of ballyhoo about new drugs cannot fail to result in a serious disservice to both patients and public.

REFERENCES

1. (a) The American Review of Tuberculosis, Vol. 65, No. 4; (b) The Quarterly Bulletin of Sea View Hospital, Vol. 13, No. 1; (c) Diseases of the Chest, Vol. 21, No. 4.

2. Morriss, W. H.: The Hydrazine Drugs, Conn. State M. J., 1952, 16:334.

3. The Second Monthly Progress Report of the VA-Army-Navy Pilot Study on Isonicotinic Acid Hydrazine in the Chemotherapy of Tuberculosis, May 1952, Veterans Administration, Washington 25, D. C.

4. Steenken, W., Jr.; Meade, G. M., and Coates, E. O.: The Antituberculosis Effect of two Hydrazines of Isonicotinic Acid, Exhibit at the Annual Meeting of the American Trudeau Society, Boston, Mass., May 26-29, 1952.

5. Howlett, K. S., Jr., and O'Connor, J. B.: Treatment of Tuberculosis With Isonicotinic Acid Derivatives; Preliminary Observations, a report to the Connecticut Trudeau Society, Hartford, Connecticut, May 15, 1952.

The National Fund

In the initial distribution of funds collected last year by the National Fund for Medical Education, 79 medical schools were benefited. To each four-year school $15,000 was given and to each two-year school $7,500. The stipulation by the trustees that these funds were for unrestricted use of the schools teaching programs has received general acclamation. In many schools it constitutes the largest unrestricted sum available for use during the school year. Thus it can be used directly to improve teaching standards.

The potentialities in the future of the fund are great if the public and professional interest can continue to expand. A most important influence in this desired end is the wholehearted participation by the doctors themselves. This is the surest way to inspire industry, business, philanthropy, and others to participate.

The doctor has interesting choices in the matter of giving. He may give to the Foundation for equal distribution among all medical schools or designate his Foundation gift for the medical school of his choice. He may, through his own alumni or other organization, give directly to a medical school in which instance he will receive credit with the Foundation.

In our own State approximately one half of the doctors to date have chosen the latter course. In addition the State Medical Society and the Woman's Auxiliary have made independent gifts.

Doctors like everyone, are subject to the pressures of many fund raising campaigns. The Foundation Fund is different however, for it is so much their own. To continue its success doctors must lead the way.

Clinical Congress — 1952

Change is essential to healthy growth. The change in the arrangements for the 1952 Clinical Congress are significant in that they serve to emphasize the primary purpose of the Congress: namely, to bring to the physicians of Connecticut the newer and important clinical aspects of disease. The change in meeting arrangements has been made in order to overcome the wastage of effort incident to meetings held in widely separated parts of the University. The increased time allotted for subject presentation is aimed to stimulate wide discussion and give more time to question periods. The change from a three-day session to two, combined with easy accessibility to meetings, is also conservative of time and effort. It is recognized that the Congress comes at a time of year usually a busy period for the practicing physician. However, this time of year for the Congress is dependent upon the use of Medical School facilities at a time when the school is not in session.

The program appears elsewhere and speaks eloquently for itself. Our guest speakers represent a galaxy of talent readily recognized for their competence in the fields they represent. Subjects important in medicine today have been chosen and show a diversification which should attract a wide interest.

The Clinical Congress this year, to be held entirely within the environs of the School of Medicine, will serve a better purpose in furthering the Medical Society and Medical School interrelationships, which are of such importance to their mutual interests.

The Hartford Circus Fire: Lawyers and Doctors

The recent airing of Ringling-Barnum & Bailey's dirty linen in the Hartford Superior Court has brought to the minds of many physicians an all too vivid picture of that terrible afternoon of July 6, 1944. The hours of constant toil to save the lives of those who reached the hospitals in Hartford was taken in stride by the local medical profession and the small number of casualties resulting among those who survived the initial holocaust bear witness to the willingness to serve without thought of compensation, a characteristic so often overlooked in criticisms levelled at the doctors of today.

Now, after eight years of legal service, the Court is informed that the bill submitted by the receiver for the circus is a bargain and really should be much

larger. Totalling up all the attorneys' fees for the settlement of nearly $4 million in claims, they amount to about 10 per cent. This probably is a reasonable figure, especially when one discovers that only through the efforts of the receiver and other attorneys was the circus kept on the road and thus able to pay claims filed against it.

This is not a time for self commendation. Rather it is a time for giving thanks that we as a people permit our hospitals and physicians to operate unhampered by any bureaucratic control. When this sizeable fee is paid for legal aid in securing just payment to the relatives of those who lost their lives in the circus fire, there will be many alive to tell the story of unselfish and uncompensated life saving service on the part of the physicians of greater Hartford. And when the hospitals appeal to the community for financial aid, those particular individuals should be the first to show their gratefulness in concrete form.

Olin West — Physician, Statesman, Friend

Olin West, one of the most colorful figures in organized medicine, has passed on. Joining the staff of the American Medical Association at a time when medical education in the United States was under fire because of the many diploma mills, Dr. West early showed his intrepid zeal and persevering courage in the fight to improve existing standards. Much of the success of the AMA in overcoming quackery and fraud in medical practice found its origin in the uncompromising character of that great man who for 23 years was the secretary and general manager of the national organization.

Olin West had many friends. A true southern gentleman, he brought to Chicago the graciousness engendered by his early years of practice in Nashville, Tennessee. During those years, Dr. West was an instructor in the Vanderbilt University School of Medicine, and for eight years he was director of the Rockefeller Sanitary Commission and the International Health Board of Tennessee. From these duties he found it relatively easy to move over to the Tennessee State Board of Health as secretary and executive officer. At different times he was president of the Middle Tennessee Medical Association, secretary of the Tennessee State Medical Association, and editor of the *Journal* of the *State Association.*

Dr. West left the Chicago scene in 1946 and returned to his native state. Ill health prevented him from returning to Chicago except on a few occasions. His familiar face was sorely missed at the annual meetings of the House of Delegates, in fact, to many of the old timers the sessions of the AMA seemed strangely lacking without the presence of his tall, erect figure and the appeals he was so wont to make for some principle he believed was in jeopardy.

We shall miss him.

Stanhope Bayne-Jones Army Medical Research Director

Stanhope Bayne-Jones, Brigadier General, retired, and former wartime medical consultant to Secretary of War Henry L. Stimson, has assumed his duties as civilian Technical Director of Army Medical Research. Dr. Bayne-Jones will serve in the office of the Army Surgeon General.

He succeeds Francis G. Blake, former dean of the Yale Medical School, who died in January of this year. Also a former dean of Yale Medical School (1935-1940), Dr. Bayne-Jones will act as consultant to Colonel John R. Wood, MC, chairman of the Army Medical Research and Development Board. He will be responsible for ensuring close coordination between the Army's present $11,650,000 medical research effort and similar programs sponsored by the other armed forces and civilian Federal agencies.

Since 1947 Dr. Bayne-Jones has been president of the Joint Administration Board of New York Hospital-Cornell Medical Center in New York City. During World War II he served in the Surgeon General's Office as Deputy Chief of the Preventive Medicine Service. During that period he also served as Administrator of the Army Epidemiological Board and as Director of the U. S. Typhus Commission. Dr. Bayne-Jones was formerly a member of the Connecticut State Medical Society.

Don't Be a Part-Time Citizen

REGISTER! — VOTE!

PROGRESS IN CLINICAL MEDICINE

NEWER ASPECTS OF FERTILITY AND STERILITY PROBLEMS

Robert H. Hepburn, M.D., *Hartford*

Before progress in therapy can be marked in any field there must be progress in understanding. At present in the study of fertility we are still chiefly in the period of the development of understanding.

ORGANIZATION

We may now discard Medicine's almost traditional attitude of helplessness toward the sterility problem. A general attack has begun, for a small but intensely active group has recently organized the American Society for the Study of Sterility. Papers presented at the annual meetings of this society have all the fascination of the latest bulletins on atomic science. These papers and others can be found in the new bi-monthly journal, *Fertility and Sterility* (begun January 1950). The basic scientist, the physician, the veterinarian are all in there with a cooperative give and take which must be read, heard, seen to be appreciated. The Ortho Research Foundation has established a prize of $1,000 awarded annually by the Society for the most significant research in fertility. A similar society has just been organized in England.

PATHOLOGY

Howard[7] et al, with testis biopsy, have demonstrated that the azoospermic or oligospermic may be suffering from prepuberal type gonad, sclerosing tubular degeneration, interstitial fibrosis, absence of germ cells, hypospermatogenesis, arrest of maturation in spermatogenesis, oligospermia with normal testicular histology, or obstructions of the ductal system. They have correlated cytologies with urinary pituitary follicle stimulating hormone (FSH) excretion (normal = 6.9–96 mouse units daily by nondialysis method), with urinary 17– ketosteroids (normal daily excretion = 8–18 mg.), and with physical findings. Where pituitary failure is primary the prospect of improvement from administration of gonadotropins is promising if given early. Obstructive lesions in the vasa are surgically correctible in some instances. Bilaterally small testes indicate irremediable pathology except when associated with low FSH and eunuchoid habitus. Small testes and normal habitus indicate noncorrectible tubular failure. Testes normal to palpation but associated with oligospermia or azoospermia suggest obstruction of the vasa, but testis biopsy must be done since arrest of maturation in spermatogenesis may be masked by a palpably normal testis. More precise correlation of size and consistency with sperm count, the relationship of these to use, and a possible cytology of over-use are undecided questions. Conclusions as to the permanence of any histological picture in the testis are suspect since the discovery of the "rebound phenomenon": testosterone administration may cause marked disruption in the testis with resultant azoospermia, but months after testosterone withdrawal the count may zoom and the cytology flourish as never before. Not infrequently low count patients show marked improvement in semen pictures following conventional therapy. Does their biopsy picture change also?

SEMEN

The establishment of norms for semen is much closer to achievement. One would think this should not be difficult. That it has been is probably due to an insufficiently analytical approach to statistics. A few years ago the standards (or, as Page[14] calls them, "guesstimates") were surprisingly rigid. It is now apparent that, except for azoospermia, there is no fixed point with regard to known seminal factors above which one may classify a patient as "fertile" or below which one may say assuredly "you are sterile." MacLeod's[9] massive analytical study of 1,000 fertile and 800 "infertile" males (so classified because of childless marriage), while admittedly still in the progress stage pending completion of studies on the wives, demonstrates that previous standards

of count normality have been far too high. While ability to conceive increases with count, motility, and superior morphology, there is no sharp cleavage between MacLeod's fertile and "infertile" groups except at a count of 20 million per cc. and below. MacLeod states, "the minimal level of normal fertility for the spermatazoon count is 20 million per cc. (a total sperm count of 50 million)." At this count level the fertile and infertile groups differ most also in morphology and motility though in these respects the difference is not so striking. The minimum normal percentage active cells according to MacLeod is 40 per cent; the minimum quality of motility should be 2 in a scale of 4. In this connection MacLeod has not been able to demonstrate that a sperm which showed feeble motility could have that motility improved by changing its environment. The custom of using duration of motility of sperm in semen as a measure of fertility is probably in error since the rise of pH in semen with time in vitro is entirely artificial compared to the relatively stable pH the sperm contend with in the cervix, uterus, and tubes; further, the sperm leave the semen to enter the cervical canal probably within a matter of a few minutes to an hour or so. The American Society for the Study of Sterility has adopted the following standard for normal semen:

Volume: not less than 2.5 cc.
Count: not less than 60,000,000 per cc.
Motility: 60 per cent must be actively motile.
Morphology: there must be 75 per cent normal forms.

This is lower with regard to count and motility than was previously considered required for normalcy but in view of MacLeod's analyses it is still too high. Page, in commenting on MacLeod's and his own large series, has pertinently observed that "if we were to remove from 5 to 15 per cent of the lowest counts, the poorest motilities, or the poorest morphologies from the 800 men of unknown fertility (MacLeod's "infertile" men) and then redistribute the remainder, we could make the fertile and the unknown groups appear identical;" which leads him to suspect that "something less than 20 per cent of husbands are responsible for infertile marriages." To further lower one's faith in the count as an indication of fertility, Chang found that in the rabbit 20,000,000 sperm injected into the vagina gave no higher tubal count than did 200,000.

That it is far easier for a group of men to agree on standards than to dig out the truth is nowhere better illustrated than in the question of morphology. It has been demonstrated that as a generality morphological "abnormality" increases with decreasing count. While it seems for example safe to call a sperm abnormal when its "abnormally" large head is bent permanently on its neck, its motility is feeble, and it swims pathetically in circles, how about the less obvious deviations from the usual—and these are legion. A variant of this problem is stated well by MacLeod: "I still want the morphologists to provide proof for their contention that if a so-called abnormal sperm fertilizes an ovum, a "poor" pregnancy will result. I know of no substantial proof on record." It may be unnecessary practically to settle this point since selection of the sperm population is so severe that only a few of the evidently most hardy and morphologically normal sperm are capable of arriving in the tube to accomplish fertilization. It does seem that some fertile men may preponderantly produce an unusually small sperm head. From his large series, MacLeod believes that 60 per cent "normal" forms in a semen specimen constitute a minimum for normality.

Some men with exceedingly low counts are fertile. They are apt to have compensating factors in motility and morphology. However, the implication is that there may be factors in the semen (or the wife), as yet unrecognized, which are responsible.

SPERM SURVIVAL IN WOMEN

At room temperature in vitro semen specimens begin to lose sperm motility progressively after several hours; most specimens show only poor motility after 24 hours. It is unusual to find motility after 48 hours. Stein and Cohen[16] have found that around ovulation time motile sperm are routinely recoverable from the endocervix for as long as 72 hours, but that pre- and postmenstrually the survival is brief and inconstant. Rubinstein et al have related the presence of sperm in the removed uterus and tubes to time of cervical exposure to semen in women subjected to hysterectomy. Sperm were found in the tubes 30 minutes after vaginal insemination. In a case operated on 50 hours after vaginal insemination there were motile sperm in the cervix, fundus, tubes. Since the fertilizability of the ovum is probably of only a few hours duration it is evident that the long survival of sperm in the female tract is a compensating mechanism to make the sperm supply more constant. Factors involved need elucidation. Meanwhile the source of sperm supply can be made of longer duration and greater abundance through

use of a cervical cap containing the semen and excluding the vagina, to whose low pH the sperm death in vaginal semen in a few hours has been attributed. Hanson and Rock report an over-all 21.4 per cent success with this and the cervical tamponade method of artificial insemination with husband semen as compared to 11.1 per cent success by the former method of merely placing the semen in the cervical canal. The fascinating question of etiology remains; why did 43.3 per cent of Hanson and Rock's[4] 271 cases of infertility have unsatisfactory postcoital tests (failure to recover motile sperm from cervical mucus several hours (postcoitally) though the ejaculates were normal with counts of at least 60 million per cc.?

Is there an antibody reaction which destroys the sperm in these couples? Diamond,[2] in a report on the relation of blood group incompatibilities to fertility and sterility, could find little evidence that such incompatibilities in general affected fertility or were related to early abortion. This need not rule out local antibody formation. The problem is still open.

May bacterial inhabitants of the normal appearing cervix in these cases be the key factor in postcoital sperm disappearance from the cervix? Matthews and Buxton[11] made cultures from the cervical canals of 100 sterility clinic patients. Then 0.5 cc. of a 24 hour incubated bacteria—beef-broth infusion was mixed with 0.5 cc. semen or sperm-Ringer-glucose suspension. This was incubated at 37°C. and motility recorded at ½, 2, 4 and 6 hours. Some of the organisms, especially E. Coli, Strep. Viridans, and Hemolytic Strep.—were highly spermicidal. Others were innocuous, especially hemolytic and nonhemolytic staph., diphtheroids, bacillary streptococci. The inference is obvious that spermicidal bacteria in the cervix should be removed by use of drugs to which the bacteria may have sensitivity demonstrated.

May estrogen insufficiency lessen sperm longevity in the cervix or estrogen excess increase such longevity? Stein and Cohen found motile sperm in cervical mucus for as long as 6 days after insemination when stilbestrol 0.1 mg. for 10 days was used. The average positive postcoital tests in these treated cases were 48 hours but they stated this was double the average of 24 hours they found in the untreated. Cervical mucus continued thin and profuse for 120 hours vs. 48 hours in the untreated. One wonders whether the stilbestrol may not have penned up the sperm in the cervix. Relief of sterility would give Stein's and Cohen's findings the therapeutic importance implied.

HYALURONIDASE

The "hyaluroni*daze* bubble" has burst in the sense that additions of this substance to semen for purposes of dissolving the coronal cell barrier to the ovum have been quite ineffective in producing conceptions, contrary to what might have been expected from earlier reports. Hyaluronidase content in semen is roughly proportional to sperm count. Wilson and Aronson[17] have described a technic for viscosimetric assay by which they hope to determine the minimum level of hyaluronidase in semen of fertile men.

Because the testis is the only part of the genitalia which produces hyaluronidase, it occurred to Michelson[12] et al that the presence or absence of hyaluronidase in the semen of azoospermics could be used as a test for patency of the ductal apparatus. Seventeen of 31 azoospermic patients produced semen containing hyaluronidase. Granting the premise, this means that 14 of the 31 azoospermic patients had duct obstruction. If so, that is a far higher incidence of this condition than generally believed heretofore.

Miller and Dessert[13] throw some cold water on the custom of administering vitamin E to "infertile" males. From their work they believe that vitamin E may regulate hyaluronidase behaviour in the body. Various tocopheryl phosphates, including d-alpha-tocopherol, have the ability to inhibit hyaluronidase. Vitamin E has probably played an exaggerated role in therapy in any case; Gulickson[3] found that the reproductive ability of cattle fed vitamin—E—poor rations was not adversely affected through 3 generations.

X-RAY

In view of enthusiastic reports, especially by Kaplan,[8] on low-dosage irradiation of pituitary and ovaries in effecting re-establishment of normal cycles in amenorrheic and oligomenorrheic women, with subsequent pregnancies, and even apparently enabling a few women with normal periods to conceive, the question arises as to the effect of low dosage irradiation on oligospermia. Charny[1] treated both pituitary and testes in 12 patients and pituitary alone in 8. The pituitary dosage, as had been given in females, was 3 exposures of 55 r each at weekly intervals; testis dosage was 3 exposures of 28 r each at weekly intervals. The semen pictures of the 8 cases receiving treatment to the pituitary did not alter. Of the 12 patients receiving treatment to testes and pituitary there were 7 with azoospermia whose semen didn't change except for diminution in number of seminiferous epithelial cells. Of the 5 oligo-

spermics, with counts respectively of 1.2 million, 5.4 million, 5.8 million, 9.0 million, and 22.5 million per cc., all specimens from the first month on after irradiation revealed azoospermia. The last of these had testis biopsy before and 6 months after treatment; the second biopsy showed marked damage to the testis with tubules only about ⅔ normal size and lined by a single layer of cells most of which were Sertoli cells. Two years after the second biopsy there was still azoospermia. Despite these discouraging results it is still possible that a smaller dose might have a stimulative effect.

THE REBOUND PHENOMENON

For over a decade it has been known that testosterone in large doses will depress sperm count, presumably by suppressing pituitary gonadotropin output. Heller et al,[6] using patients institutionalized because of mental deficiency, have recently correlated testicular cytology with testosterone administration. Similar changes occurred in every case: decrease in size of seminiferous tubules, necrosis and sloughing of germinal elements, arrest of sperm formation, decrease in numbers of germinal elements, absence of Leydig cells, atrophy of detectable interstitial cells. Biopsies obtained 12-30 months after discontinuance of testosterone revealed, when compared to the original biopsies, either marked improvement or, in the case of initially excellent biopsies, an equally good picture. An "infertile" male sterility patient, with a sperm count of 3 to 4 per low power microscopic field and elevated gonadotropins, was then treated for 1 month with 100 mg. testosterone propionate daily. Twenty-three months after onset of azoospermia the count was 63 million.

Heckel and McDonald[5] have just (June, 1951) reported on about 70 patients treated with testosterone 50 mg. 3× per week intramuscularly. Thirty-six were satisfactorily followed. Twenty-three showed rebound and 5 wives of these 23 had become pregnant at the time of the report. Rebound took 24-81 weeks to reach a peak. One patient went from 45,000,000 per cc. to 340,000,000 per cc. One was still azoospermic after 9 weeks. One azoospermic patient rose to 45,000,000 per cc. then some 20 weeks later was again azoospermic. Two other patients recessed to pretreatment levels after 43 and 73 weeks following the peak of rebound. Some of the nonresponding patients may merely be slow. It is known that chicken-pox and other diseases may cause severe depression of sperm count, but there is prompt recovery. It is strange to have to wait so long for rebound to occur. Perhaps testicular damage is greater with testosterone. Because several reported cases have had apparently permanent azoospermia from testosterone administration, the general impression at present is that only extremely oligospermic patients should be treated with testosterone in an effort to produce rebound.

There are of course many more aspects of progress in fertility and sterility both with regard to the male and female which have not been considered above because of necessary limitations of this article. Those interested in the field will find the broadest spectrum of subject matter palatably presented in the journal, *Fertility and Sterility*.

REFERENCES

1. Charny, C. W.: Fertil. & Steril., Vol. 1, No. 2, 150-157, 1950.
2. Diamond, L.: Paper presented at Atlantic City Meeting, Am. Soc. for Study of Steril., June, 1951.
3. Gullickson, T. W.: Ann. N. Y. Ac. Sci., 52:256-259, 1949.
4. Hanson, F. M., and Rock, J.: Fertil. & Steril., Vol. 2, No. 2, 162-173, 1951.
5. Heckle, N. J., and McDonald, J. H.: Paper presented at Annual Conference, Am. Soc. for Study of Steril., June, 1951.
6. Heller, C. G., Nelson, W. O. et al: Fertil. & Steril., Vol. 1, No. 5, 415-422, 1950.
7. Howard, R. P., Simmons, F. A., and Sniffen, R. C.: Fertil. and Steril., Vol. 2, No. 2, 95-111, 1951.
8. Kaplan, I. I.: Fertil. & Steril., Vol. 1, No. 2, 123-144, 1950.
9. MacLeod, J.: Fertil. & Steril., Vol. 2, No. 2, 115-139, 1951. Fertil. & Steril., Vol. 1, No. 4, 347-361, 1950.
10. MacLeod, J., and Gold, R. Z.: Fertil. & Steril., Vol. 2, No. 5, 394-414, 1951.
11. Matthews, C. S., and Buxton, C. L.: Fertil. & Steril., Vol. 2, No. 1, 45-52, 1951.
12. Michelson, L., and Koets, P.: J. Urol. 61:803-805, 1949.
13. Miller, W. H., and Dessert, A. M.: Ann. N. Y. Ac. Sci., 52:167-179, 1949.
14. Page, E. W., and Houlding, F.: Fertil. & Steril., Vol. 2, No. 2, 140-151, 1951.
15. Rubinstein, B. B., Strauss, H., Lazarus, M. L., and Hankin, H.: Fertil. & Steril., Vol. 2, No. 1, 15-19, 1951.
16. Stein, I. F., and Cohen, M. R.: Fertil. & Steril., Vol. 1, No. 2, 169-175, 1950. Fertil. & Steril., Vol. 2, No. 1, 20-27, 1951.
17. Wilson, L., and Aronson, W:: Fertil & Steril., Vol. 1, No. 3, 254-258, 1950.

THE PRESIDENT'S PAGE

MEDICAL education has become a perennial subject for discussion not only in our community but throughout the country. The commission appointed by Governor Lodge to study the need for a state supported medical school in Connecticut is now engaged in this survey. It is expected that this representative committee will return an exhaustive as well as a definitive report on the subject, one of great importance to the doctors of the State as well as to the general public.

A recent issue of the *New England Journal of Medicine* carries an editorial on the subject of a new medical school in Massachusetts, a recommendation made by a commission appointed by the Governor of the Commonwealth. The editorial writer makes the interesting suggestion that as an alternative to an additional medical school an effort should be made to improve postgraduate medical training in the hospitals of the State. The suggested plan would make the hospital an extension of the university with the hospital educational plan subsidized by the State.

It is recognized by medical educators as well as by clinicians that the residency training as established in some hospitals falls far short of what is considered adequate training for the specialties. The dissatisfaction expressed by some residents with their service is due not to the lack of clinical material but rather to the absence of a training plan in hospitals that are only passably equipped to provide an educational program that will supplement the teaching of the mechanics of the specialties.

Revolutionary changes have been taking place in medicine and the allied sciences during this era when medical and other scientific research has been carried on in such a feverish manner. Medical education, both undergraduate and postgraduate training, must be adjusted to this increased tempo if the education of a physician is to include the knowledge uncovered by modern research. If the interne and residency years are the important years in the long training required to produce a trained physician, the State might well invest its funds to the extent of underwriting the educational program in those hospitals where a residency program is in force. Such an investment on the part of the State would bring immediate and abundant returns.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

Council Meeting

The Council extended its activities into the summer by holding a meeting on June 26. The meeting was held at the offices of the Society and called to order at 4:00 in the afternoon by the President of the Society in the temporary absence of the Chairman of the Council. Later the Chairman joined the meeting. There were present: Drs. Danaher, Feeney, Fincke, Gallivan, Gettings, Howard, Labensky, Phillips, Root, Russell, Shepard, Tracy, Ursone, Whalen, Barker, Gibson. Absent: Drs. Archambault, Buckley, Couch, Flaherty, Gens, Gildersleeve, Murdock, Thoms, Walker, Weld. Dr. Gibson and Dr. Feeney, newly elected Speaker and Vice-Speaker of the House of Delegates met with the Council for the first time.

RESPIRATOR TREATMENT CENTER

The secretary reported concerning a conference with the medical staff of the National Foundation for Infantile Paralysis in regard to the establishment of a Respirator Treatment Center in Connecticut. It was voted to appoint a committee to negotiate with the National Foundation in connection with the development of the Connecticut Respirator Treatment Center. The committee appointed was: Chairman, Oliver L. Stringfield, Stamford; George G. Fox, Meriden; Wilson F. Smith, Hartford; F. Erwin Tracy, Middletown.

ADDITION TO COMMITTEE ON PUBLIC RELATIONS

Dr. John O'L. Nolan, chairman of the Hartford County Association Committee on Public Relations was appointed a member of the Committee on Public Relations of the State Society.

COMMITTEE ON THIRD PARTY PAYMENTS

In compliance with the By-Laws passed by the House of Delegates at its annual meeting in 1952, the Council appointed an interim Committee on Third Party Payments to serve until the regular nominations and elections can be held during the annual meeting of the House of Delegates in 1953. The committee appointed was: Chairman, Walter I. Russell, New Haven; Sidney S. Quarrier, Hartford; Berkley M. Parmelee, Bridgeport; Henry A. Archambault, Taftville; Lewis P. James, Hartford.

PHYSICIANS IN STATE SERVICE

The secretary reported on the progress of the Society's intercession in the approval of the recommendations concerning classification and salaries of physicians in Connecticut state service contained in the report of the study made by the Barrington Associates. The secretary, on behalf of the Society, had offered an advisory committee to the Governor to discuss this subject, if such was his wish. As yet, no fixed arrangements have been made for such a committee to act and the matter continues to be a subject of conference between representatives of the Governor's Office, the Personnel Department, and the secretary of the Society. It was agreed that the Society should appoint such a committee to be ready to act if the Governor requests it. The following committee was appointed: Chairman, Creighton Barker, Joseph H. Howard, Clifford D. Moore.

HYPERTENSIVE DISEASE IN FIREMEN

A recommendation from the committee on Public Health that the attention of the Council be directed to the need for review and possible revision of Section 175b of the General Statutes of the Connecticut 1951 Supplement was discussed at some length.

"Section 175b. Disability to Firemen Caused by Hypertension or Heart Disease." Notwithstanding the provisions of any general statute or special act to the contrary affecting the noncontributory or contributory retirement systems of any municipality of the state, as defined by section 680, any condition of impairment of health caused by hypertension or heart disease resulting in total or partial disability to a uniformed member of a paid fire depart-

ment of such municipality who successfully passed a physical examination on entry into such service, which examination failed to reveal any evidence of such condition, shall be presumed to have been suffered in line of duty."

It was voted that no action be taken on this subject and although it was not included in the vote, the discussion disclosed the opinion of the Council to be that the subject of this legislation was only remotely related to public health and welfare and other areas of legislation in which the Society should have special interest.

STATE PLANNING COMMITTEE ON POLIOMYELITIS

A proposal was presented from Dr. James C. Hart of the State Department of Health that the Society name a representative to be a member of a State Planning Committee on Poliomyelitis which is now being organized by the State Department of Health. Oliver L. Stringfield, Stamford, was proposed as the Society's representative on this committee.

CONNECTICUT NUTRITION COUNCIL

The continuation of membership in the Connecticut Nutrition Council was discussed and it was agreed that the Society should maintain its membership in the Council and Dr. Max Caplan, Meriden, be continued as the representative from this Society.

CLINICAL CONGRESS DINNER

The question of having a dinner on Wednesday, September 17, during the 1952 Clinical Congress was discussed and a number of suggestions were offered. It was agreed that such a dinner be held and the secretary be directed to arrange a program according to proposals that had been accepted by the Council.

1953 ANNUAL MEETING

Dr. Gettings, a member of the 1953 Annual Meeting Local Committee on Arrangements from the New Haven County Medical Association, discussed the preliminary plans that are being made for this meeting. It is proposed to have the meeting at the Hamden High School during the spring school recess.

CONNECTICUT MEDICAL SERVICE

Dr. Danaher presented a report on the transactions of the Executive Committee of Connecticut Medical Service that was held on June 23. The report touched upon extension of direct payment coverage by Connecticut Medical Service, the agency agreement with Connecticut Hospital Service and the need for additional office space for Connecticut Medical Service.

Only Sixteen Missing

There have been 114 presidents of this Society since its founding in 1792. The search for pictures of these distinguished gentlemen has been richly rewarding and portraits of all but 16 of them have been obtained. The list of the missing ones is given below and it will be greatly appreciated if all members of the Society will use their ingenuity and make inquiry of every reliable source so that pictures of them all may be obtained.

1792 Leverett Hubbard, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1832 William Buel, Litchfield
1834 Thomas Minor, Middletown
1843 Luther Ticknor, Salisbury
1853 Richard Warner, Cromwell
1865 Nathan B. Ives, New Haven
1867 Charles Woodward, Middletown
1873 Ira Hutchinson, Cromwell
1878 Charles M. Carleton, Norwich
1883 Elisha B. Nye, Middletown
1885 Elijah C. Kinney, Norwich
1893 Francis D. Edgerton, Middletown
1895 Seth Hill, Stepney
1905 Edward H. Welch, West Winsted

Meetings Held in July

July 1—Local Committee on Arrangements
July 2—Program Committee—Annual Meeting
July 7-8—Connecticut Medical Examining Board
July 8-9—Connecticut Medical Licensing Examinations
July 10—Committee on Medical Care of Veterans
July 15—Woman's Auxiliary
July 15—Poliomyelitis Treatment Center Committee
July 17—Connecticut Medical Examining Board Executive Meeting
July 24—Executive Committee of the Cancer Society

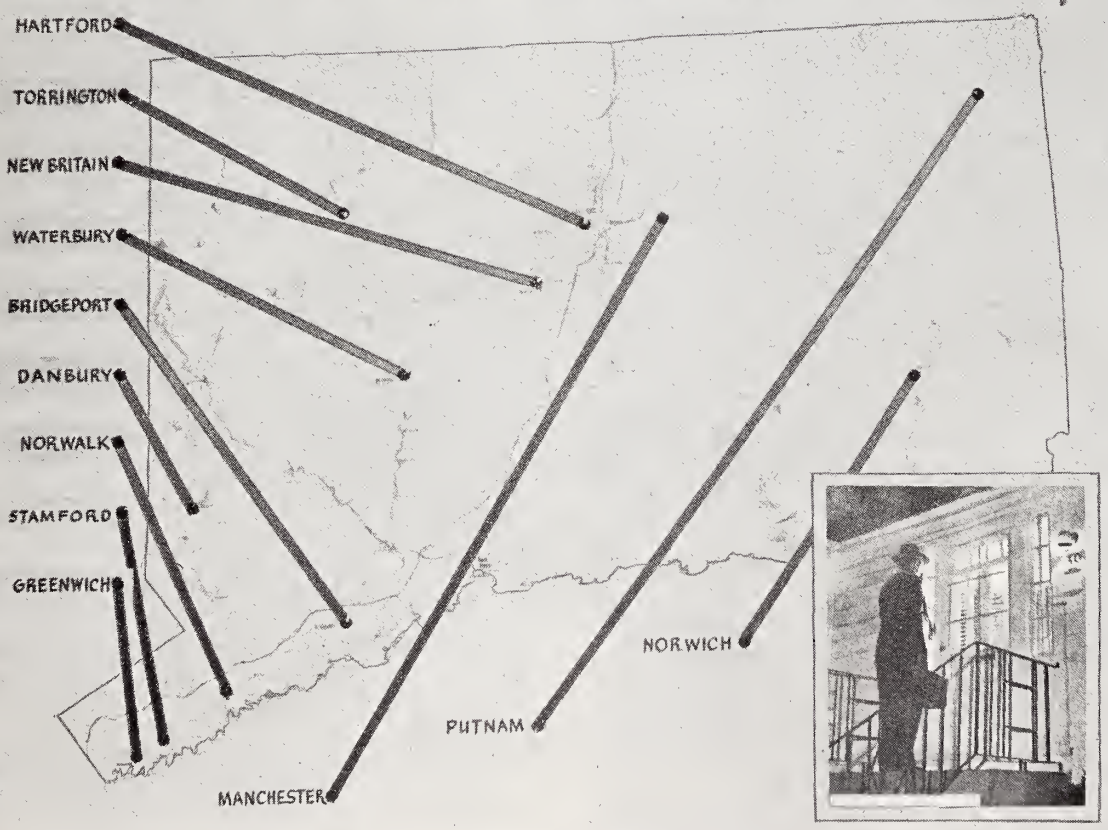
EMERGENCY MEDICAL SERVICES

Emergency services are being sponsored by medical associations for more than one million Connecticut residents, half the state population.

These systems assure speedy attention in emergencies. They radiate from 12 centers of population and are augmented by physician-hospital emergency plans.

Medical associations are sponsoring these services in 400 American communities and the number is increasing steadily.

Connecticut State Medical Society



PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette Jay Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon

Documentary Film Sponsored by AMA Ready for Community Theaters

RKO-Radio Pictures is ready to release a documentary film, "Your Doctor," to community theaters from coast to coast.

The American Medical Association worked closely with writers, directors and cameramen during production of the fifteen minute film. It tells the story of Dr. George Bond's North Carolina mountain clinic, of how medical students are trained and of the relationships between physicians and their medical societies.

"Never before has a film put the medical profession in such a favorable light," states Dr. George F. Lull, AMA secretary and general manager, in a recent letter urging state and county medical societies to assist local theaters build a sizeable audience.

RKO-Radio estimates its own promotion will place the film on the screens of 3,000 theaters, reaching an audience of fifteen million people. If county and state medical societies work with them, RKO-Radio believes "Your Doctor" can be booked in almost 5,000 theaters and viewed by thirty million people.

Bookings of the film in Connecticut theaters are being planned so that screening will begin the latter part of August. Promotional information and materials are to be made available to county public relations committees prior to screening dates.

More Than $600,000 Raised in First Five Months of 1952 AMEF Campaign

Contributions to the American Medical Education Foundation's 1952 campaign passed the $600,000 mark in its first five months of activity.

In a report prepared for the June session of the AMA's House of Delegates, Dr. Elmer L. Henderson, Foundation president, stated that 2,500 contributions had been received as of May 23, more than the total number of all contributions in 1951.

The Connecticut campaign, directed by the Society's Committee on Public Relations, totalled $8,583 as of July 1, seven months following its inception early last December. This result has been in response to two campaign mailings and represents contributions by 188 physicians.

A second phase of the campaign, development of local fund-raising activities, is now being studied by the committee. It is anticipated that plans for this extension of the campaign will be ready for action following the semi-annual meetings of county associations in October.

Public Relations Committee Starts New Service

A new information service to furnish component associations with useful information concerning medical public relations activities has been inaugurated by the Society's Public Relations Committee.

The service comprises publication of a newsletter, *PR Guide*, and preparation of kits of material to aid development of community service programs.

The first issue of *PR Guide* was published July 9. Plans call for several issues a year, dependent on the level of public relations activities and problems. The mailing list will include members of medical public relations committees and officers of county medical associations.

The first kit of materials to be offered by the new service is now in preparation. It concerns methods of planning information programs in connection with community service activities and will soon be available for public relations committees.

New London Medical Society Studies Emergency Plan

Members of the New London Medical Society recently authorized appointment of a committee to study medical coverage of emergency calls.

Similar studies are being conducted by the New

Haven Medical Association and the Central Medical Society, Middletown.

Telephone emergency systems for medical coverage are now operating in twelve principal communities under sponsorship of county and local medical associations. These systems are located in Hartford, New Britain, Waterbury, Bridgeport, Stamford, Torrington, Danbury, Greenwich, Norwalk, Manchester, Norwich and Putnam.

First Medical PR Institute in September

The American Medical Association's first Medical Public Relations Institute will be held in Chicago September 4 and 5.

Primarily established for public relations personnel of state and county medical societies, the Institute will be a workshop-type conference dealing with the operational techniques of medical PR programs.

The Institute will supplement the annual Medical Public Relations Conference to be held in Denver December 1, just prior to the AMA Clinical Session.

The Use of ACTH and Cortisone in the Treatment of Rheumatic Fever — A Preliminary Statement on the Cooperative Rheumatic Fever Study

Early in 1951 an international study of the treatment of rheumatic fever was set up with the object of measuring the relative values of ACTH, cortisone, and aspirin. This cooperative study, first of its kind in this field, is being conducted in 13 research centers in the United States, Great Britain, and Canada by the American Heart Association's Council on Rheumatic Fever in conjunction with the British Medical Research Council.

A preliminary report of the findings was made by a Panel of investigators engaged in the study at a joint scientific session of the Council on Rheumatic Fever and the American Rheumatism Association in Chicago on June 7, 1952. A summary statement, which follows, was presented by the Moderator for the Panel, Dr. David D. Rutstein, Boston, chairman of the Committee on Criteria and Standards of the Council on Rheumatic Fever.

The text of the statement is as follows:

"A group of investigators in the United Kingdom, Canada and the United States initiated in January 1951 a cooperative study on the relative value of ACTH, cortisone and salicylates in the treatment of rheumatic fever and the prevention of rheumatic heart disease. The plan of study provides for uniform criteria for the diagnosis of rheumatic fever and for the degree of rheumatic activity required for the admission to the study, the random allocation of patients to the three treatment groups, a defined dosage schedule of the drugs for a fixed period of time, a specified period of observation following treatment and a long term follow up schedule. It also lays down precisely the frequency and type of clinical and laboratory observations to be carried out on each patient.

"To date, in all three countries, 658 cases have been admitted to the study and the analysis of rather less than half of these is the basis of the preliminary report. These cases were analyzed for changes in those symptoms, signs and laboratory observations usually considered important in evaluating the course of acute rheumatic fever. In the type of cases admitted to the trial and with the regime of treatment laid down, it appears that individual symptoms, signs or laboratory observations may have been affected more favorably by one or another of these three drugs, but no consistent pattern is evident. In short, no firm conclusions can at present be drawn concerning the drug most effective in the control of the acute illness. The cases have not been under observation sufficiently long to provide data on the prevention of rheumatic heart disease.

"Admission of new cases to the study will be brought to an end later this year. It is anticipated that a total of 750 cases will be available in all three countries for complete and detailed analysis of the effects of the drugs on the acute course of the disease and later, after adequate follow up, on the prevention of rheumatic heart disease."

Funds for the study are being supplied by the National Heart Institute of the U. S. Public Health Service, the British Medical Research Council, the hospitals and medical centers in the local communities involved in the study, the Armed Forces Epidemiological Board, the United States Air Force, the American Heart Association, and the Canadian Arthritis and Rheumatism Society. The supply of ACTH required for the study was given by Armour and Company, and the cortisone supply was given by Merck and Company.

Rabies Prophylaxis

W. McD. Hammon, M.D., *Head of Department of Epidemiology and Microbiology, Graduate School of Public Health, University of Pittsburgh*

Rabies prophylaxis, in the light of past and present evidence, conflicting recommendations, and gaps in actual knowledge, places any physician in a difficult position who is called upon to treat a patient with potential rabies exposure. From many articles by competent authorities it appears that the following statements are at least partially substantiated by reasonable evidence.

1. It is postulated that rabies will develop in only about 10 per cent of persons bitten by a rabid animal and not treated.

2. Fuming nitric acid treatment of a bite wound may be less effective or no more effective than copious, deep irrigation of a fresh wound with large amounts of aqueous soft soap.[1] The former has certain serious disadvantages, particularly when applied to the face or neck.

3. The effectiveness of any currently available rabies vaccine administered to man after a bite by a rabid animal has been seriously questioned.

4. Any form of Pasteur treatment is associated with a definite though small risk of serious and sometimes fatal postvaccinal demyelinizing paralysis or encephalitis. In some areas where administered indiscriminately, without carefully weighing the rabies risk versus the vaccination risk, it is reported that more persons have been killed or crippled by vaccine administation than would have suffered from rabies had no vaccine been available.

5. A hyperimmune antirabies serum concentrate developed by Drs. Koprowski and Cox of Lederle Laboratories will prevent rabies in hamsters and guinea pigs when administered after the injection of virus.[2] This serum is available for experimental administration to man in cases where it can be administered within 72 hours after the bite of animals definitely suspected of having rabies. This serum is available in only limited quantities. It is recommended that it be given in connection with a modified (abbreviated) vaccination schedule. From the theoretical and experimental standpoint, immunologists and virologists are inclined to approve this type of passive-active prophylaxis.

This available collection of opinion places physicians in an unenviable position when an "exposed" patient seeks his help. What is his position in court if he departs from the most conservative, traditionally accepted methods? What is best for the individual case for which he has moral responsibility? Every "exposed" person presents a complex individual problem which requires careful evaluation. The physician must consider whether the patient has been exposed sufficiently so that the risk of vaccination is less than that of rabies. He should recall that absence of an actual bite wound or an open cut or abrasion where saliva has had contact essentially eliminates any risk of infection. A bite from an apparently normal animal that can be confined and held under observation by a qualified veterinarian should not be considered an exposure until or unless the latter believes the animal has begun to show signs of rabies. If an apparently well animal is infectious at the time of biting, he can be expected to show signs of illness within a very few days, almost certainly in less than ten days. If rabies vaccine is begun pending clinical observation of the animal or the pathologic examination of its brain, vaccine injections may be stopped on receipt of negative evidence. The risk of a few injections of vaccine is much less than that of an extended or completed series.

In regard to follow-up on any available animal which has bitten the patient, the following may be of some assistance. Almost any warm blooded animal may be rabid. Dogs, foxes, cats, skunks, wolves, woodchucks, etc., can transmit the disease through the virus in their saliva. If the animal is behaving abnormally at the time of biting, it should be sacrificed without head injury and the whole head submitted to a suitable laboratory for examination. If possible, a laboratory should be selected which will submit the specimen to at least three approved types of tests: impression smear, sections, and animal inoculation. A preliminary report will be submitted if Negri bodies are observed by examination of the quickly prepared impression smears. Preparation of sections will require slightly more time and may be more reliable, while animal inoculation requires a minimum period of about a week but may reveal positives missed by the other methods.

The greatest difficulty is presented by the person who is bitten by an animal that cannot be located and whose actions have not been observed by anyone mature enough to give an intelligent, objective, and reliable description of its actions and the circumstances leading to the attack. It is difficult to generalize recommendations for these circumstances.

Patients who have been potentially "exposed" should be given every possible encouragement and the danger minimized as long as they remain cooperative, because fear of this disease is usually tremendous and misinformation from lay sources is

frequent. There are numerous accounts of deaths from hysteria where no rabies existed. It should be recalled that a bite through clothing is much less dangerous than one which permits no wiping of saliva from the teeth. It should also be emphasized that man is relatively insusceptible to rabies and that many bites by rabid animals will not result in rabies, regardless of prophylactic measures used. Minor bites are less dangerous than severe or multiple lacerations. Fear may be greatly alleviated by carefully imparting this information to the patient.

If any neurologic disorder or other reaction develops in the person who is receiving Pasteur treatment, he should be studied carefully immediately with the possibility in mind that sensitization to the vaccine is responsible. If such appears to be likely, injections should be stopped, for further severe damage might result from even one more injection.

If rabies develops in a patient, since there is no specific therapy, heavy sedation to relieve the extreme anxiety and painful muscle spasms must be the mainstay of therapy. Barbiturates appear to be more suitable than opiates.

It is apparent from the above that control of rabies at the human level is fraught with uncertainties and is highly unsatisfactory. True rabies control must be applied at the level of the reservoir in the animals, and only where that has failed need one attempt human prophylaxis. Measures for animal rabies control are well developed in theory and practice, but may fail due to many inexcusable human factors. Despite the current availability of these admittedly effective control measures, Pennsylvania now has an acute rabies problem. Much of this appears to be due to the selfish actions of certain individuals or groups who have managed through political influence to place their own interests above that of the health of the community. It is our duty to see that the control in foxes and dogs is adequately carried out in all communities of the State and that enforcement is maintained at all times, not just sporadically after one or more human lives have been lost.

REFERENCES

1. Shaughnessy, A. J., and Zichis, J.: Prevention of Experimental Rabies, J. A. M. A., 123:528-533, 1943.

2. Koprowsky, Hilary, and Cox, H. R.: Recent Developments in the Prophylaxis of Rabies, J. Am. Pub. Health, 41:1483-1489, 1951.

Reprinted from Pennsylvania Medical Journal, April 1952

The Rh Factors

Some confusion still exists in regard to the nomenclature and interpretation of the various Rh factors. Therefore, it seems advisable to review briefly the routine procedure followed by the Connecticut Regional Blood Center in reporting these types.

There are three Rh factors, or types, called C, D, and E. The most important of these is the D, followed in order by the C and the E. An individual may possess any or all of these factors, or none of them.

Under the method of reporting used from June 1950 to April 1951, a donor who possessed any of the Rh factors was classified as Rh positive. A donor who lacked all three Rh factors was classified as Rh negative. At the present time, the laboratory tests a donor's blood for only the D and C factors, since the E is rarely encountered, and is therefore omitted from consideration by the Blood Center as a distributing agency.

The routine procedure in testing for and reporting the Rh type is as follows:

(1) The donor's red blood cells are tested for the presence of the D factor. If D is present (positive), it is not necessary to test for the C factor. This donor is classified as D positive.

(2) If the D factor is absent (negative for D), the donor's cells are tested for the C factor. If the C factor is present, this donor is classified as D negative C positive.

(3) If both D and C factors are absent, the donor is reported as CD negative.

INTERPRETATION AND INCIDENCE

(1) Individuals who are positive for the D factor are considered Rh positive for all purposes, both for donating and receiving blood. These comprise 85 per cent of the population.

(2) Individuals who possess the C factor but not the D (D negative C positive) are considered Rh positive for donating blood, but Rh negative for receiving blood. These comprise 2 per cent of the population.

(3) Individuals who are negative for both the D and C factors (CD negative) may be regarded as Rh negative for all purposes, both for donating and receiving blood. These comprise 13 per cent of the population.

Offering -- nationally famous makes of

FURNITURE, EQUIPMENT and SUPPLIES including:

W. D. Allison Company

Shampaine Company

Ritter Company

Welch-Allyn Company

Johnson & Johnson

Armour Laboratories

Raytheon Manufacturing Co.

Birtcher Corporation

J. Sklar Manufacturing Co.

Davol Rubber Company

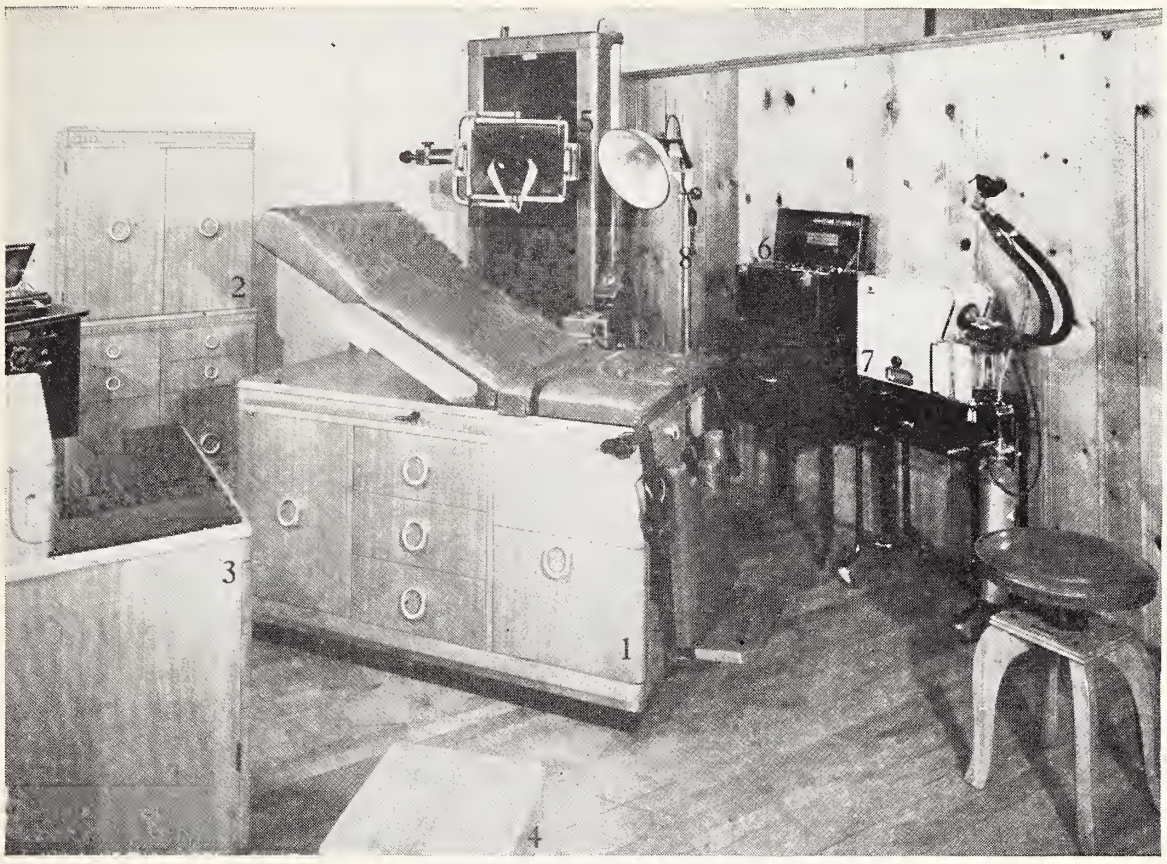
Seamless Rubber Company

Becton, Dickinson & Company

Americaine, Inc.

North American Philips Co.

and many others



One section of our large display room in Bridgeport

Telephone 5-3116 -- Enterprise 3190

American Surgical

SUPPLY and EQUIPMENT CO.

1715 BARNUM AVENUE P. O. BOX 150

BRIDGEPORT, CONNECTICUT

NEWS FROM WASHINGTON

Social Security Bill Passes: Disability Section Requires Action Next Year

On Saturday, July 5, Congress enacted HR7800, the social security bill, after Senate-House conferees had written into it a new section on disability which in effect postpones final decision on this controversial question until next year. This section is designed to waive payment of old age and survivors insurance premiums by persons who are totally and permanently disabled. The House bill gave the Federal Security Administrator unusual control over medical examinations for the purpose of determining disability. American Medical Association had objected to this as an unwarranted grant of power, but had not objected to other parts of the bill. The Senate bill had no provision at all for waiver of premiums.

Now only the President's expected signature is needed to make law the following compromise, worked out by conferees and approved by both houses:

1. A new disability section, giving states rather than the Federal Security Administrator control over medical examinations for the purpose of determining total and permanent disability. It is understood the procedure would be similar to that now in effect for medical examinations of needy permanently and totally disabled persons who wish to be certified for Public Assistance grants. But—

2. The section can't go into effect until Congress again has acted on it. This section (but not others) will terminate on June 30, 1953—one day before the date set for filing of the first claims. This self-contradictory arrangement was worked out to insure that full hearings could be held next year before the disability section could become operative. Chairman George had demanded that his Senate Finance Committee have this opportunity.

3. Other provisions, not subject to termination with the disability section, include monthly increases of $5 or 12.5 per cent, whichever is the larger, for O.A.S.I. beneficiaries; the right of a retirement age worker to earn $75 per month without sacrifice of pension (present law is $50, House asked $70, Senate $100); persons temporarily in military service to receive social security credit at the rate of $160 per month earnings; U. S. payments to states for aid to needy aged, blind and disabled raised $5 per month, payments for dependent children $3, but states are not required to pass these payments along; these Public Assistance increases terminate September 30, 1954.

Medical Legislation Enacted

In day and night sessions over July 4 weekend, Congress passed and sent to the White House the following major bills of medical interest: Appropriations for Federal Security Agency and Veterans Administration, "Fair Trade," Social Security Amendments, Mine Safety, reorganization of the military reserves, a GI bill for veterans with service since the start of the Korean War and extension of the Water Pollution Control Act. The Senate also refused to consider emergency maternity and infant care bill. The House passed a bill allowing veterans a 2 year presumptive period for psychosis but Senate took no action.

Other Bills Passed

In a rush of activity, both houses completed action on the following:

1. Bills to continue the $100 per month special pay for military and U. S. Public Health Service physicians and to authorize commissions for women physicians in the regular medical corps of the three services; both signed by the President.

2. The immigration bill, with a provision giving preferential treatment to physicians and other highly skilled persons; passed over the President's veto.

3. Legislation to allow taxpayers to deduct up to 20 per cent rather than 15 per cent of their gross income for contributions to charitable, educational and other organizations; sent to the President for signature.

Lehman EMIC Bill Altered

Although S2337 dies with 82nd Congress, its revamped language and the printed report that accom-

panied it are worthy of notice since they will command attention when subject of health care of servicemen's dependents is revived this winter, as it is sure to be. Significantly, revised version of bill adheres closely to EMIC plan of World War II, dropping controversial Title II which provided government paid hospitalization benefits for all dependents of enlisted personnel, regardless of condition under care or treatment. Maternity and infant care is now the sole objective of S2337, though "infant" is defined liberally as a child up to age five. A proviso is included that makes osteopathic physicians and hospitals eligible for participation in program.

Department of Defense is giving increased attention to problem, seeking a solution that will give it, rather than Federal Security Administrator, administrative control. Secretary Lovett has named a new committee to make a comprehensive study and submit recommendations in the fall.

Defense Department to Investigate Problems of Dependents' Medical Care

Defense Secretary Robert Lovett has appointed a committee to look into the problems connected with care of military dependents. It plans to hold its first meeting in August and make a report in about a year. Dr. Melvin Casberg, chairman of Defense Department's Medical Policy Council, was named chairman of the committee. Other members will be the three chiefs of staff, the assistant secretary of defense, W. J. McNeil, who handles fiscal matters, and assistant secretary Anna Rosenberg, in charge of manpower.

Current policy of the military departments is to provide medical care to dependents where such care is "available." This means families living near a post with adequate medical facilities can benefit, but those living elsewhere generally cannot. One of the questions facing the committee is whether the services themselves should attempt to provide maternity and infant care for all service dependents.

Earlier this year at Senate Health Subcommittee hearings on EMIC bills (emergency maternity and infant care for enlisted men's dependents), Defense Department spokesmen said military medical departments were handling about 70,000 maternity cases annually. (The EMIC bill, S2337, came up in the Senate on July 5, but it was objected to and failed to pass.)

Health Commission Schedules First Meetings Open to Press

As a prelude to its open regional hearings in August, the President's Commission on the Health Needs of the Nation scheduled its first open sessions since the commission was formed last December. Seventeen medical and lay authorities on July 9 and 10 summarized the findings of seven all-day panels held during May and June. They make their report to the full commission. Chester I. Barnard, acting chairman, while Dr. Magnuson is in Europe, stated:

"We have decided to open the two-day meeting to the press because of the tremendous interest the general public is showing in our work. We want the people to get a better insight into the impartial manner in which the hearings are held. . . ."

Salary Stabilization Board Modifies Health and Welfare Requirements

To bring its health and welfare plan requirements in line with the new code adopted by Wage Stabilization Board, Salary Stabilization Board has revised its own regulations. If the plan covers only employes subject to jurisdiction of SSB, it may be put into effect without prior approval of SSB under two conditions:

1. It must cover at least a majority of the employes subject to jurisdiction of SSB "and may not discriminate in favor of employes who are officers, shareholders, supervisors or highly compensated employes."

2. Benefits must be consistent with prevailing practice and, among other restrictions, must not provide for payment for ". . . total and permanent disability of the employe . . ."

Also, the new regulations eliminate the requirement that employes must contribute 50 per cent of the premium for benefits for their dependents; no payment by the employe for his dependents is required. (For complete details, write Office of Salary Stabilization, Washington 25, D. C., and ask for General Salary Stabilization Regulation No. 8, Revised.)

VA Economizes

Veterans Administration in June spelled out how it has saved taxpayers more than $137,000,000 in administrative costs over the last 4 years without

impairing service to veterans, their dependents or beneficiaries.

Many of these savings, VA said, are recurring—that is, they will continue from year to year so that the ultimate savings will be considerably larger.

The savings were computed from a long list of management improvement actions that Carl R. Gray, Jr., Administrator of Veterans Affairs, presented before the House Veterans Affairs Committee recently in giving an accounting of his stewardship as Administrator from 1948 to the present.

In the medical and hospital field, Mr. Gray listed the following actions:

1. It was known that a number of veterans hospitalized for nonservice connected conditions in VA hospitals had some form of prepaid hospitalization or medical insurance coverage. In fiscal year 1948, VA initiated a standard procedure with the objective of collecting from the insurance companies. Between mid 1948 and the present, $7,200,000 has been collected by VA which would not otherwise have been paid the Government by the insurance companies.

2. The blood bank program now established within VA is a result of the cooperation of the professional field, as well as local organizations and service groups. Prior to the establishment of VA's 50 blood banks, 95 per cent of all blood utilized was purchased. The blood bank program reduced the total amount of money required by VA to purchase blood by $2,900,000 between 1949 and the present.

3. As an economy measure, VA attempts to standardize drug items stocked in hospitals and regional offices, providing every medication requirement but limiting duplication by avoiding stocking of several items under different trade names. The careful screening and standardization of drugs as a result of this activity has reduced the total amount of money which otherwise would have been required for this item by approximately $1,000,000 between 1949 and the present.

4. The development of ration pattern control in 1950 has enabled VA to absorb the full increase in food prices with no increase in the amount of money being spent for food during that year and without any undesirable effect on the quality of medical care provided to patients. Net savings in food costs resulting from the establishment of the standard ration pattern was $330,000 in fiscal year 1950, $4,130,000 in 1951, and $1,845,000 in the first 10 months of fiscal 1952 for a total of $6,305,000.

5. The VA manufactures as many pharmaceutical preparations as possible in station pharmacies at considerable savings under the cost for purchasing the manufactured items. To date, this practice has reduced the amount which otherwise would have been required for drugs by a total of approximately $1,200,000.

6. Control of overtime costs in hospitals without impairing service to veterans has resulted in an estimated savings of $2,500,000 to date.

ILO Votes Social Security Treaty, Including Compulsory Health Insurance

The International Labor Organization, meeting in Geneva, has approved a convention (treaty) on minimum standards of social security in nine fields—medical care, sickness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. Approval came over objections of employer delegations from many countries. The U. S. employer spokesman was quoted as saying employers would be against the entire convention because of the medical care section alone. A government may be listed as ratifying the convention if it promises to meet the requirements in four of the nine fields of social security.

The medical care section stipulates that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: (a) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (b) private, voluntary health insurance administered by insurance companies but under government "supervision." Coverage would have to average about 50 per cent of the population.

Government sources agreed privately that chances of U. S. ratification were very slight at this time. However, there is no time limit on ratification. It was learned that the U. S. delegation had sought (a) to have the ILO conference agree that only one of the nine requirements had to be met for ratification and (b) that it be in the form of a recommendation rather than the more binding convention. The U. S. delegation voted in favor of the convention, but a spokesman for the delegation was quoted as saying this did not imply that the U. S. would accept the entire convention.

The State Department and the President will decide whether to submit the convention to the

Senate for ratification. Ratification would require a two-thirds vote, which would place this country under obligation to put at least four of the nine programs in operation.

The U. S. delegates are Senator Murray (D—Montana) and Assistant Secretary of Labor Philip M. Kaiser, representing government; George P. Delaney of the American Federation of Labor, representing employes, and Charles P. McCormack, president of McCormack Tea & Spice Co., Baltimore, employer representative. They were assisted by a staff of 25 advisors.

Committee Recommends Law to Test Chemicals Added to Foods

The third report of the House Select Committee Investigating the Use of Chemicals in Foods praises the food industry for much of the progress in the field of nutrition but recommends that the Food, Drug and Cosmetics Act be amended to give Food and Drug Administration more control over foods. The Committee recommends that proof of the safety of chemical additives be submitted to the FDA before chemically-treated foods are offered for sale. It points to the increasing use of chemicals in food production, processing, storage, packaging and distribution and to testimony delivered before the Committee that some of these chemicals have not been tested properly and might be dangerous.

Monograph on Toxoplasmosis Advances Some New Concepts

Newly published by Public Health Service is "Toxoplasmosis," a 105-page monograph (91 illustrations) by Drs. Jacob K. Frenkel, of National Institutes of Health, and Saul Friedlander, of Mercy Hospital, Sacramento, California. It presents clinical histories of five fatal and two surviving cases in infants, together with autopsy findings of four of the fatal cases. A considerable portion of the report is devoted to evidence in support of a new concept concerning pathogenesis of central nervous lesion in infants. Authors point out that fetal infections with measles, German measles, poliomyelitis and other viral invasions may lead to malformations simulating toxoplasmosis. Latter's true incidence is unknown, according to authors, since many cases go unrecognized and others are not recorded. "Toxoplasmosis" may be purchased (50 cents) by mail order from Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Report Shows Growth of Voluntary Health Plans

Published in July by Health Insurance Council is its annual survey of accident and health coverage in U. S., depicting notable strides made in 1951. On December 31, 85,991,000 persons were under hospital expense protection; 65,535,000 held surgical care insurance and 27,723,000 medical care. This represented increases, respectively, of 12, 20 and 28 per cent, in comparison with estimates for 1950. The Council's survey included Blue Cross, Blue Shield and other voluntary nonprofit plans as well as those underwritten by insurance companies, whose nine business associations comprise the Health Insurance Council. A 6 per cent gain in disability and sickness, insurance is noted in the report, which estimates that nearly two-thirds of nation's 61 million employed workers are covered by this type of protection through group or individual insurance, paid sick leave in government service and private industry, organized labor plans and employe benefit associations. "The dramatic expansion in voluntary health coverage," says report, "reflects the desire of the American people to help themselves, whenever possible, in meeting the costs of accident and sickness through methods of their own choice."

Manuscript Editing Service

For those medical writers who find it difficult to cross the last hurdle in producing finished copy ready for publication, the American Medical Writers Association offers a manuscript editing service at a moderate charge. All of our writers do not need this service but those who do may obtain detailed information about the service from Harold Swanberg, M.D., secretary, 209-224 W.C.U. Building, Quincy, Illinois. If in doubt as to your need for such a service, ask one of the editors of the JOURNAL.

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Induction Needs

Army is asking Selective Service to supply 100 physicians, and Air Force 350, for induction in August, Navy's Reserve pool still being ample to fill immediate needs. Navy is suggesting to its Priority II Reserves that they volunteer now for active duty, else they may be called up in a few months and lend-leased to Army or Air Force irrespective of their wishes as to choice of service.

Survey of Discharge Medical Personnel

From time to time the AMA receives criticisms from physicians in the Armed Forces with respect to their military assignments and their loss of contact with their professional organizations. Following World War II, an extensive survey was made of discharged medical personnel and many of the sources of complaint were eliminated through the cooperation of the offices of the Surgeons General of the three branches of the Armed Forces.

The Council on National Emergency Medical Service has announced that it is again distributing questionnaires to all physicians discharged from the Armed Services since July 1, 1951. This survey is being conducted to evaluate the use to which doctors are being put in the service, to determine the amount of time spent in supplying medical care to other than service personnel, and to determine how the American Medical Association can better serve medical personnel in uniform.

In addition to providing a service to physicians on active duty and in reserve status, it is hoped that the results of the studies will serve as the basis for recommendations concerning the "Doctor Draft Law." This law, which originally was enacted on September 9, 1950 for the purpose of supplying physicians for the Armed Forces, is due to expire on July 1, 1953. It will be necessary for the association to recommend to the Congress at that time whether such draft legislation should be extended or terminated, and, if extended, the form it should take.

VA Extends Outpatient Care to Veterans of Korean War

Veterans Administration has announced that it will provide or pay for outpatient medical and dental services required by post-Korea veterans on the presumption that the conditions requiring care or treatment are service connected. If certain requirements for eligibility are fulfilled, outpatient treatment will be authorized and permitted to be continued pending adjudication by VA as to whether the cases are genuinely service connected. If the finding is negative, care will be discontinued. In order to qualify for outpatient dental care (most of which is performed by private practitioners on a fee basis), the post-Korea veteran must file his application within 12 months following discharge.

Veterans Pensions Increased

Connecticut veterans now receiving a $60 or $72 a month pension for nonservice connected disability, and who now need regular aid and attendance of another person, may be entitled to an additional award to increase their pension to $129 on July 1, according to Manager Harry T. Wood of the Veterans Administration Hartford Regional Office. Such veterans must apply to the VA to receive the "aid and attendance" benefit, as VA does not automatically review cases now on its rolls to determine if they qualify for the added award, Wood said. The effective date of the "aid and attendance" award is the date the claim is filed.

Wood pointed out that effective July 1, there will be some automatic pension increases. Sixty dollar payments go to $63; $72 to $75; and those now receiving $120, including the aid and attendance award, will receive $129. Pensions are payable to war veterans, subject to certain limitations, who become permanently and totally disabled from causes not due to service. The basic rate before the July 1 increase is $60, increased to $72 after ten years of continuous receipt or when the veteran reaches the age of 65. The new $129 rate will not be

applicable during periods when the veteran is being hospitalized or furnished domiciliary care by VA.

Alcoholic Clinics Join With Motor Vehicle Commission

The Board of Commissioners on Alcoholism has voted to cooperate with the State Motor Vehicle Commission in a joint project under which all the resources of the Alcoholism Commission will be made available to the Motor Vehicle Department. When a request for reinstatement of an operator's license is received from an individual about whom the Motor Vehicle Commission is in doubt, the man or woman will be referred to an outpatient alcoholism clinic. The professional staff of the clinic will attempt to determine whether there is a problem of alcoholism involved and, when indicated, will recommend treatment. If the individual who is an alcoholic refuses to accept treatment, the clinic will report this to Commissioner Kelley's office. When a treatment plan is followed successfully, this will become a matter of record and will be considered in reviewing the request for reinstatement of the operator's license.

Connecticut Heart Association Announces Additional Research Grants

Recent allocations for cardiovascular research in Connecticut totaling $9,800 have been announced by Dr. Arthur J. Geiger, chairman of the Research and Grants Committee of the Connecticut Heart Association. This brings to $35,190 the total amount of funds allocated by the Committee since its organization in January 1951. The most recent grants were made to the following:

William L. Glenn toward establishment of a blood vessel bank at New Haven Hospital for state-wide service and to conduct researches in improved technics for blood vessel preservation.

Averill Leibow for study of pulmonary and systemic vascular changes in experimentally induced emphysema.

Max Carter for continuation of studies toward surgical amelioration of mitral insufficiency.

Gustaf Lindskog for surgical attempts at revascularization of the myocardium by autogenous splenic grafts to pericardium.

Frieda and Frank Gray for continuation of studies on the pathogenesis of rheumatic lesions.

William L. Glenn for investigation of results of lumbar sympathectomy in peripheral vascular disease of various types.

A. V. N. Goodyer for studies on role of autonomic nervous system and humeral mechanisms in renal responses to cardiovascular stress.

Frank Gray for studies on influence of drugs on blood flow in collateral pulmonary artery channels in pulmonary heart disease.

Louis Nahum for studies on the electrical field of the heart.

In addition to the above grants made directly by the Connecticut Heart Association, the American Heart Association has announced 72 grants-in-aid totaling $361,522.50 of which two were made to Connecticut individuals as follows: Allen V. N. Goodyer—$5,775—influence of blood flow on metabolism and excretion of salts. William T. Salter, $3,885, metabolic basis for heart failure and for treatment of this condition.

These grants bring to $1,300,000 the total allocated for heart research by the National organization, its state affiliates and their local chapters during the fiscal year just ended.

Summer Slump

The problem of providing an adequate supply of blood by the Connecticut Regional Blood Bank does not take a summer vacation. The demand continues at a high level while the donors and recruiters take a holiday.

The profession well recognizes that whole blood cannot be stock piled to overcome this difficulty and the only answer is for all concerned to add their mite to the procurement of donors.

The physician can be of inestimable help to those volunteer workers who are recruiting for the Connecticut Regional Blood Program by adding a word of encouragement to the families and friends of prospective blood recipients.

FROM OUR EXCHANGES

The *Monthly Bulletin of the State of Connecticut Department of Labor* for September 1951 contains an historical sketch of Hartford as the insurance center of the nation. Of interest to physicians may be the fact that more than 100 periodicals have been established in Hartford, notably *The Children's Magazine* (1780), the first juvenile periodical in America; America's first cook book written by Amelia Simmons (1796); the *Hartford Courant* (1764) and the *Hartford Times* (1817).

* * * *

"Chronic Infections of the Middle Ear" by Atkinson appears in *Journal of Arkansas Medical Society* (48.4). Progress in prevention of chronic suppurative otitis media and its complications during recent years the author attributes to the good results from early myringotomy together with the specific antibiotics plus the prophylactic use of the latter in the treatment of infections involving the perinasal sinuses and the nasopharynx. The complications of chronic suppurative otitis media are discussed under seven headings: (1) brain abscess; (2) meningitis; (3) epidural abscess; (4) thrombosis of lateral sinus; (5) petrosis; (6) facial paralysis; and (7) labyrinthitis. The medical or conservative treatment is extreme cleanliness of the external canal, clearing up of purulent sinus infection, use of drugs active against both gram positive and gram negative bacteria. Surgical treatment is emphasized for certain cases. Even with the decline in incidence of this disease, from two to four per cent of the population are believed to be affected.

* * * *

Gerbode of San Francisco discusses "Surgical Treatment of Acquired Heart Disease" in *California Medicine* (75.9). Success in surgical treatment of certain cardiac malformations has led to a renewed interest in the treatment of acquired heart disease. The possibilities of surgery of severe wounds of the heart and adjacent blood vessels are discussed, also of tumors of the heart and pericardium, arteriovenous fistula, coronary artery disease, constrictive pericarditis, and constrictive valvular disease.

* * * *

In "Helpful Points in Diagnosis and Treatment of Liver Disease," Stauffer of Mayo Clinic *(S. Dakota Jour. Med.* IV.9) points out the outstanding clinical features for diagnosis and the few basic principles in the treatment of diseases of the liver. He divides his subject into hepatitis, classification of jaundice, extrahepatic obstructive jaundice, cirrhosis, other causes of hepatomegaly, and needle biopsy of the liver. Reference is made to the steady stream of patients with serum jaundice following the indiscriminate use of plasma. The types of cirrhosis are classified as (1) typical portal (Laennec's), (2) portal (fatty type), (3) postnecrotic, (4) primary biliary, and (5) obstructive biliary. Most of the cases of hepatitis encountered appear to be of the sporadic variety with an occasional small epidemic. Needle biopsy is a useful diagnostic aid in liver disease. Its value has been established in metastatic carcinoma, cirrhosis, hepatitis, hemochromotosis, and amyloidosis.

* * * *

The New England Journal of Medicine (245.22) contains a review of the literature together with a case report of gastric ulcer in the preschool child by Goldsberry. According to Proctor's criteria, 41 cases of gastric ulcer in the preschool child have been reported in the literature since 1843. Abstracts from these histories are given. In the author's case, x-ray examination demonstrated a definite ulcer crater. The patient made an uneventful recovery after two weeks on antacid, bland diet and bed rest.

* * * *

A case report of psychogenic vomiting treated with Dramamine was published in *New England Journal of Medicine* (245.24) by Kaplan, Hirsch and Flowers. The dramamine was used as an adjuvant measure and was followed by intensive psychotherapy. Various investigators have reported Dramamine to be effective in the nausea and vomiting of motion sickness, after operative procedures, following aureomycin therapy, after electric shock, in radiation sickness, and in hyperemesis gravidarum. The authors found no case in the literature where it was used in psychogenic vomiting on the basis of a conversion hysteria in the absence of labyrinthine or other organic disease.

* * * *

The aged sick have always attracted attention as individuals, and most of us who are ourselves aging

are sympathetic to their distress and unmet needs. It is refreshing to read such pithy comments as are contained in an address by Mortimer O'Sullivan, M.B., B.CH. reported in the *British Medical Journal*, No. 4771. The point of view of this general practitioner will be of interest to his opposites in this country, especially in light of his experience under the present conditions of practice in England. Some of his thoughts are condensed as follows.

Any service dealing with the aged should be so designed as to make it easier to nurse the patient at home. Hospitalization or local authority accommodation solves the problem for the relatives and the general practitioner, but in most cases not for the patient. Old people do not take kindly to removal from their usual surroundings.

For the general practitioner there is no clear dividing line between the chronic sick proper and the aged infirm. This classification is of importance to him only when the question arises of removing them from their homes. In general practice the aged are persons who require more or less constant medical supervision and a considerable amount of personal attention.

The problem has become more acute, particularly in urban areas, principally because (1) people live longer, (2) the neighborhood "handy woman" has disappeared, (3) housing is not adequate in amount or in unit size to avoid domestic friction, and (4) "because weekly contributions are paid to the State there is a feeling that it is the duty of the State to nurture and nurse, and that the care of the aged is no longer the responsibility of the family."

Dr. O'Sullivan comments on the need to take occupational and physical therapy into the home. There should be check ups by laboratory tests at regular intervals and care of the feet should be made easy in "foot clinics." "Many of the aged infirm become the chronic sick and confined to the house because their feet give out. The old age pensioner cannot afford the fees of a private chiropodist. The establishment of foot clinics would postpone the immobility of the aged."

Care has to be taken lest the aged suffer from malnutrition, lest they become dirty and unwashed and lest they be left alone many hours at a time in solitude. An interesting suggestion is found in the following: "In some cases the relatives would be prepared to look after and care for an aged sick person if a contribution were made to the family budget. After all, if the patient has to occupy a hospital bed it costs the country about 15 guineas a week. In suitable cases anyone who takes on the arduous duties of nursing an aged sick relative should be compensated. Is it possible for a relative to be appointed a home-help with overtime pay for week-end work?"

The following suggestions are offered: (1) Admission to hospitals or homes during the family holiday. "It is the continuity of care that gets the family down;" (2) supplies of bed clothes and night attire for the incontinent; (3) Male nurses; (4) Sick visiting. "There is a great opportunity here for the churches. If more interest were shown in the aged sick there might be a chance of the younger people taking an interest in church affairs;" (5) Increase in number of district nurses; (6) Priority hospital accommodation for certain dying patients.

"Whatever the future of medicine in this country, the chronic sick and aged infirm will in the main be the responsibility of general practice."

School Administrators Conference

Several physicians participated in the Conference on Administrative Problems in School Health Education held in connection with the Health Education Seminar at the Department of Public Health of Yale in July. Leonard C. Menczer and Franklin Erlenbach represented the Hartford and State Health Departments, respectively. Francis L. DePasquale, supervising physician for the Hartford Board of Education, and Frank W. McCarthy, Jr., school physician for West Hartford, discussed school health problems. James C. Hart from the State Department of Health and Bertram E. Marks, Middletown health officer, discussed the communicable disease problem in the schools.

Heart Association Makes Awards

The American Heart Association has approved 72 grants in aid totalling $361,522.50 for research work in 20 States, the District of Columbia, Montreal, and Beirut, Lebanon. Two of these awards were made to Yale University School of Medicine as follows: $5,775 to Allen V. N. Goodyer for studies of the influence of blood flow on metabolism and excretion of salts; $3,885 to William T. Salter for studies of the metabolic basis for heart failure and for the treatment of the same.

OBITUARY

Thomas J. Roche, M.D.
1883 - 1952



To all outward appearances death came suddenly to Dr. Thomas J. Roche on April 30, yet, knowing Dr. Roche we believe that in his heart and soul he was prepared. He was a deeply sincere individual, well aware for a long time of his own precarious health and resigned to the imminent possibility of a sudden passage into eternity.

Born in Westerly, R. I., son of the late David and Catherine Kirby Roche, Dr. Roche attended public schools in Westerly and was graduated as a registered pharmacist from the Rhode Island College of Pharmacy. He entered the drug business in Westerly and later, since he was predominantly interested in medicine, he enrolled in the University of Maryland College of Physicians and Surgeons from which he was graduated in 1911.

Dr. Roche served his internship at the Bridgeport Hospital and in July 1912 began the practice of medicine in Bridgeport. Four years later he was appointed assistant in gynecology and obstetrics at the Bridgeport Hospital and in 1921 became attending obstetrician. In 1939 he was named chief of the obstetrical service, retaining that position until illness forced him to retire in 1947.

A former president of the Bridgeport Medical Association, Dr. Roche was a member of the Fairfield County Medical Association and the American Medical Association. He also belonged to the American College of Surgeons, International Academy of Medicine, Knife and Stork Club, and was a member for fifty years of the Knights of Columbus. He is survived by his wife, Mrs. Anna McGoldrick Roche; two sons, Thomas K. Roche and David J. Roche; two daughters, Miss Marie A. Roche and Mrs. Margaret Bryant; two brothers, George and David Roche; two sisters, Mrs. Louis Willemin and Miss Agnes Roche; six grandchildren, two nieces and four nephews.

Dr. Roche loved truth and had no use for sham. He cared not for the adulation of others but he did esteem very greatly their appreciation of his own sincerity. He faced life frankly without posing and with no desire other than to know the truth. He was loyal to the last to the fundamental elements of goodness, honor, justice and good will, all of which were wrought into the tapestry of his soul.

After death the memory of the greatest men must fade and perish even among those with whom they labored and to whom they gave themselves unstintedly, but we who knew Dr. Roche feel sure that he will be long remembered for his many acts of kindness and his charity towards his fellowmen.

Farewell dear comrade
tried and true
Our prayer for peace
goes out to you.
Your soul shall be
where the heroes are
And your memory shine
like the morning star.

John Shea, M.D.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
irst Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville

1952 ROSTER OF WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

Board of Directors 1952-1953

OFFICERS	NAME AND ADDRESS
President	Mrs. Barnett Freedman, 322 George St., New Haven
President-Elect	Mrs Dewy Katz, 140 Fern St., Hartford 5
1st Vice-President	Mrs. Morton Arnold, Windham Center
2nd Vice-President	Mrs. Newell Giles, Watch Tower Rd., Darien
Recording Secretary	Mrs. Edward F. Malloy, 90 Hubbard Ave., Stamford
Corresponding Secretary	Mrs. Edward T. Wakeman, Sperry Rd., Bethany
Treasurer	Mrs. Norman Barker, R. F. D. No. 1, Canton Center
Past President	Mrs. F. Irwin Tracy, 202 Old Mill Rd., Middletown

County Presidents

Fairfield	Mrs. C. M. Gratz, Cognewaugh Rd., Cos Cob
Hartford	Mrs. C. E. Jacobson, 45 Wyllys St., Manchester
Litchfield	Mrs. Andrew Orlowski, 64 Belleview Ave, Torrington
Middlesex	Mrs. Charles Russman, Connecticut State Hospital, Middletown
New Haven	Mrs. Orvan Hess, Old Orchard Rd., North Haven
New London	Mrs. Martin O'Neil, Tift St., Jewett City
Windham	Mrs. Frederick Beardsley, Columbia

Standing Committee Chairmen

Art	Mrs. Bernard Brody, Hilltop Rd., Hamden
Civilian Defense	Mrs. E. Roland Hill, 43 East Main St., Mystic
Editorial	Mrs. Paul Vestal, Amity Rd., Woodbridge
Finance	Mrs. William V. Wener, 22 Harland Pl., Norwich
Historian and Necrologist	Mrs. Edwin R. Connors, 416 Boston Ave., Bridgeport
Hospitality	Mrs. Louis Antupit, 90 Bainbridge Rd., West Hartford
Legislation	Mrs. William M. Shepard, Westview Rd., R. F. D. No. 2, Putnam
Medical and Surgical	Mrs. Joseph Woodward, 47 Hillside Rd, New London
Membership	Mrs. Morton Arnold (1st Vice-President)
Nurse Recruitment	Mrs. Chris H. Neuswanger, 64 Hillcrest Ave., Watertown
Program	Mrs. Newell Giles (2nd Vice-President)
Parliamentarian	Mrs. Winfield Wight, 24 Goodwin Court, Thomaston
Publicity and Press	Mrs. M. J. Carl Allinson, 133 West Park Ave., New Haven
	Mrs. Samuel Climo, 23 Woodside Ter., New Haven
Public Relations	Mrs.
Revisions	Mrs. Arthur Jackson, Washington
School Health	Mrs. Creighton Barker, 119 Armory St, New Haven
Special Gift Fund	Mrs. James Douglas Gold, 839 Myrtle Ave., Bridgeport
Today's Health	Mrs. Samuel Jaffe, 35 Rogers Rd., Hamden

Advisory Committee to Woman's Auxiliary

Chairman, Dr. Harry C. Knight, Middletown
Dr. Edwin R. Connors, Bridgeport
Dr. Thomas M. Feeney, Hartford
Dr. Barnett Freedman, New Haven
Dr. Winfield O. Kelley, Norwich
Dr. Kenneth K. Kinney, Willimantic
Dr. Hyman A. Levine, New Haven
Dr. Frank L. Polito, Torrington

Fairfield County

President	Mrs. Charles Murray Gratz	Cognewaugh Rd., Cos Cob
President-Elect	Mrs. Joseph H. Howard	122 Eastwood Rd., Bridgeport
Vice-President	Mrs. Mark Gildea	111 Arcadia Ave., Bridgeport
Recording Secretary	Mrs. J. Colman Kelly	30 Highview Ave., Old Greenwich
Corresponding Secretary	Mrs. William I. Glass	386 Taft Ave., Bridgeport
Treasurer	Mrs. Alexander McNamara	3354 Main St., Bridgeport
Art	Mrs. John Maher	2184 Main St., Stratford
Civil Defense	Mrs. Fritz Meyer	70 Lake St., Bridgeport
Finance	Mrs. Edwin Connors	416 Boston Ave., Bridgeport
Historian	Mrs. David McGourty	95 Hope St., Stamford
Hospitality	Mrs. William Morgan	193 Main St., Westport
Legislature	Mrs. E. C. Weise	42 Hill Top Dr., Bridgeport
Membership	Mrs. Mark Gildea	111 Arcadia Ave., Bridgeport
Nurse Recruitment and Scholarship Chairman	Mrs. T. Smith McLean	80 Oriole Lane, Trumbull
	Mrs. Meyer Abrahams	1 Colonial Court, New Canaan
	Mrs. Clifford Moore	7 Oakshade Ave., Darien
	Mrs. Anthony Apuzzo	17 Villa Ave., Bridgeport
Parliamentarian	Mrs. J. D. Gold	839 Myrtle Ave., Bridgeport
Program	Mrs. Vincent Gorman	3050 Old Town Rd., Bridgeport
Projects	Mrs. William Geer	468 Prospect Dr., Stratford
Publicity and Public Relations Co-Chairman	Mrs. Duncan Stephens	14 Knollwood Dr., Greenwich
	Mrs. J. B. Zielinski	1349 Huntington Tpke., Nichols
Revisions	Mrs. Newell Giles	Watchtower Rd., Darien
School Health	Mrs. Leo Nymovich	80 Third St., Stamford
Sunshine	Mrs. Ralph Tella	105 Woodmere Ave., Stamford
Telephone	Mrs. Edwin Trautman	5367 Main St., Long Hill, Bridgeport
Today's Health	Mrs. R. H. Dorian	60 Fifth St., Stamford
Ways and Means	Mrs. Charles Sheard	76 Glenbrook Rd., Stamford
Advisor	Mrs. John Bucciarelli	93 East Ave., New Canaan

BRIDGEPORT

Mrs. Joseph M. Adzima, 409 Noble Ave.
Mrs. Anthony A. Apuzzo, 17 Villa Ave.
Mrs. Maurice I. Bakunin, 105 Brooklawn Ave.
Mrs. S. J. Baum, 609 Atlantic
Mrs. Abraham Bernstein, 542 Maplewood Ave.
Mrs. T. P. Birney, 1984 Park Ave.
Mrs. Cyril Blaney, 3203 Main
Mrs. Rudolph Braun, 525 Clinton
Mrs. Michael Brodsky, 1075 Wood Ave.
Mrs. John W. Buckley, 2080 North Ave.
Mrs. Bernard J. Burns, 636 West Taft
Mrs. A. P. Capobianco, 29 Bayberry Rd.
Mrs. Phillip Carroll, 1131 Noble Ave.
Mrs. Louis Castaldo, 287 Fairmount Ter.
Mrs. V. J. Cavaliere, 1350 Brooklawn Ter.
Mrs. Cornelius S. Conklin, 468 Clinton Ave.
Mrs. Edwin Connors, 416 Boston Ave.
Mrs. Nicholas Creaturo, 1286 East Main
Mrs. M. Dean, 1697 Noble Ave.
Mrs. Joseph DeLuca, 124 Seaside Ave.
Mrs. L. DelVecchio, 60 Crown
Mrs. Joseph Esposito, Colony Rd., Long Hill
Mrs. Francis Foley, 3100 Main
Mrs. Carl Gade, 365 Toilsome Hill
Mrs. Charles B. Gaffney, 610 Brooklawn Ave.
Mrs. G. J. Geanuracos, Marne
Mrs. Mark Gildea, 111 Arcadia Ave.
Mrs. William Glass, 386 Taft Ave.
Mrs. James D. Gold, 839 Myrtle Ave.
Mrs. William Goodrich, Lake Ave.
Mrs. Vincent Gorman, Old Town Rd.
Mrs. David S. Greenspun, 153 Southwood Rd.
Mrs. John H. Grossman, 1708 Huntington Tpke.
Mrs. Luther C. Heidger, 244 Mill Hill Ave.
Mrs. Joseph Hennessey, 482 Brewster
Mrs. Benjamin Horn, 754 Clinton Ave.
Mrs. Martin L. Horn, 94 Terry Pl.
Mrs. Joseph Howard, 122 Eastwood Rd.
Mrs. Elwood K. Jones, 152 Balmforth
Mrs. Eugene Kalman, 622 Clinton Ave.
Mrs. Leon Kaplan, 1174 Laurel Ave.
Mrs. Harold Kleinman, 2051 North Ave.
Mrs. Alfred Kornblut, 1539 Fairfield Ave.
Mrs. Paul T. Lengyel, 500 Clinton Ave.
Mrs. Ralph J. Lenoci, 1822 Noble Ave.
Mrs. Albert Levinson, 49 Blockman Pl.
Mrs. Milton Lieberthal, Buena Vista Rd.
Mrs. R. H. Lockhart, 36 Brooklawn Pkwy.
Mrs. Michael Luciano, 2089 North Ave.
Mrs. Sidney Luria, 422 Toilsome Rd.
Mrs. Grover A. Lyon, 2009 North Ave.
Mrs. E. P. McCreery, 649 Clinton Ave.
Mrs. A. P. McNamara, 3354 Main
Mrs. L. L. Markley, 657 Clinton Ave.
Mrs. Ed. F. McGovern, 904 Lafayette
Mrs. John A. Maxwell, 773 Huntington Tpke.
Mrs. Fritz Meyer, 370 Lake Ave.
Mrs. George Molnar, 63 Elmwood Pl.
Mrs. Louis Oros, 555 Clinton Ave.
Mrs. Andrew Panettieri, 233 Algonquin Rd.
Mrs. Thomas J. Pascal, 1560 Noble Ave.
Mrs. D. W. Pasquariello, 2969 Main
Mrs. M. Popkin, 1671 Noble Ave.
Mrs. John Russo, 3296 Main
Mrs. Robert Russo, 115 Terry Pl.
Mrs. Joseph W. Saidel, 2151 Park Ave.
Mrs. J. J. Sciarillo, 4150 Main
Mrs. Michael V. Sciortini, 2072 North Ave.

Mrs. Arthur Sekerak, 408 Barnum Ave.
Mrs. C. J. Shea, 1152 Park Ave.
Mrs. John P. Simses, 28 Newman Pl.
Mrs. S. Spencer, 3400 Main
Mrs. Nicholas Spinelli, 1285 Noble Ave.
Mrs. Charles H. Sprague, 29 Hanover
Mrs. Michael Sulzyski, 355 Noble
Mrs. Thomas Tarasovie, Church Hill Rd.
Mrs. Clifton G. Taylor, 51 Brooklawn Pl.
Mrs. Edwin Trautman, 5367 Main, Long Hill
Mrs. Frank Turchik, 48 Plymouth Ave.
Mrs. Alex J. Tutles, Hillside Hospital
Mrs. Milton Unger, 97 Livingston Pl.
Mrs. I. Uvitsky, 3101 Main
Mrs. Edward R. Vioni, 3450 Main
Mrs. Eugene Walzer, 35 Lilalyn Dr.
Mrs. Ellwood Weise, 42 Hill Top Dr.
Mrs. Elmo D. Zsiga, 303 Clinton Ave.

COS COB

Mrs. Charles M. Gratz, Cognewaugh Rd.
Mrs. Ameda Losiat, 19 Salem

DANBURY

Mrs. John D. Booth, 46 Deer Hill Rd.
Mrs. George Eckert, 394 Main
Mrs. R. Ruiz, 6 Fairfield Ave.
Mrs. William A. Sunderland, 158 Deer Hill
Mrs. Ward B. DeKlyn, 21 Lawncrest Ave.

DARIEN

Mrs. C. Louis Fincke, 6 Juniper Rd.
Mrs. Newell W. Giles, Watch Tower Rd.
Mrs. Robert C. Keys, 10 Birch Rd.
Mrs. Russell A. Keddy, 15 Phillips Lane
Mrs. Clifford D. Moore, 7 Oakshade Ave.
Mrs. J. B. Ogilvie, 14 Circle Rd.
Mrs. Allan Ross, 188 Post Rd.

EAST NORWALK

Mrs. William H. McMahan, Jr., Sasqua Hills
Mrs. Ralph Padula, Pine Hill Rd.

EASTON

Mrs. Michael J. Cardonne, Sport Hill Pkwy.
Mrs. William H. Curley, Jr., Sport Hill Pkwy.
Mrs. John R. Gulash, Sport Hill Pkwy.
Mrs. Louis Murdock, R. F. D. 1, Box 400

FAIRFIELD

Mrs. Daniel C. Barker, 104 Rowland Rd.
Mrs. D. M. Biehn, 47 Parkway
Mrs. S. L. Biehn, 137 Reef Rd.
Mrs. Maxwell Bogin, 333 Cornel Rd.
Mrs. C. Virgil Calvin, 71 Old Field Rd.
Mrs. Joseph Chiota, 37 Eastwood Rd.
Mrs. W. H. Curley, Sr., 300 Collingwood Rd.
Mrs. Edmund N. DeWitt, 331 Unquowa Rd.
Mrs. Edmund Eddy, 122 Paritan Rd.
Mrs. Frederick Kinder, 920 Redding Rd.
Mrs. Owen Groark, 99 Barlow Rd.
Mrs. Paul A. Harwood, Jr., 360 Mine Hill Rd.
Mrs. A. B. James, 378 Penfield Rd.
Mrs. M. N. Levy, 203 White Oak Rd.
Mrs. Coleman Lopatin, Lynbrook Rd.
Mrs. S. Meltzer, 73 Carlynn Dr.
Mrs. Henry J. Messinger, 1597 Post Rd.
Mrs. Benjamin Reiter, Congress Ave.
Mrs. Harold Ribner, 142 Colony
Mrs. Julius Stein, 53 Warwick Ave.
Mrs. Sidney Zaur, 15 Stoneleigh Rd.

GLENBROOK

Mrs. Richard Barber, 125 Holmes Ave.

GREENWICH

Mrs. Harold L. Amoss, 68 Deerfield Dr.
Mrs. Stephen Derkach, 36 Mason
Mrs. Edwin Kent, Round Hill Rd.
Mrs. Clayton Mather, Parsonage Rd.
Mrs. Leslie Morrissett, 261 Lake Ave.
Mrs. Duncan Stephans, 40 West Elm
Mrs. William B. Swarts, Warwick Towers
Mrs. John Walker, Rock Ridge

LORDSHIP

Mrs. J. F. Paget, 282 Park Blvd.

NEW CANAAN

Mrs. Meyer Abrahams, 1 Colonial Court
Mrs. E. Tremain Bradley, Wydendown
Mrs. John A. Bucciarelli, 93 East Ave.
Mrs. H. S. Coombs, 276 South Ave.
Mrs. John Paul Gens, West Rd.
Mrs. William Terhune, Silver Hill, Box D
Mrs. Ralph White, 178 South Main

NEWTOWN

Mrs. Henry L. Clow, Box "W"

NORWALK

Mrs. William Johnson, 37 High
Mrs. Louis A. Guilliano, Appletree Lane
Mrs. Thomas Ippolito, 31 Buckingham Pl.
Mrs. Edmund Longworth, 55 East Ave.
Mrs. John D. McMahon, 10 Willow

NICHOLS

Mrs. J. B. Zielinski, 1349 Huntington Tpke.

OLD GREENWICH

Mrs. J. Colman Kelly, 30 Highview Ave.
Mrs. Frank Raffaele, Binney Lane
Mrs. Harold Wright, Sound Beach Ave.

RIVERSIDE

Mrs. Warren Brock, Sheephill Rd.
Mrs. Leonard A. Howard, 2 Tyler Lane
Mrs. Anthony Intriere, Riverside Lane
Mrs. E. H. Wyatt, 14 Winthrop Dr.

SAUGATUCK

Mrs. Harold Genvert, Old Saugatuck Rd.

SHELTON

Mrs. J. Grady Booe, Long Hill Ave.
Mrs. Ralph Edson, 77 Oak Ave.

SOUTH NORWALK

Mrs. James Davis, 282 West Ave.
Mrs. Henry J. Gloetzner, Belle Island
Mrs. Martin Paley, 111 West Ave.

SOUTHPORT

Mrs. H. Patterson Harris, Jr., 382 Mill Hill Rd.

SPRINGDALE

Mrs. Simon Goldfarb, 124 Crestwood Ave.

STAMFORD

Mrs. Robert Abrahamson, 107 Glenbrook Rd.
Mrs. Earl M. Adams, 205 Strawberry Hill Rd.
Mrs. E. H. Barnes, Box 892
Mrs. Addison Bissell, 66 Glenbrook Rd.

Mrs. Malcolm Boshnack, Sherwood Rd.
Mrs. Stewart Bowman, 39 Revonah Rd.
Mrs. Paul Brown, 140 Woodside Village, Apt. 39
Mrs. John J. Cloonan, 182 Seaton Rd.
Mrs. Joseph Connally, 104 South
Mrs. Frank D'Andrea, 191 Hubbard Ave.
Mrs. Irving Dichter, 171 Hubbard Ave.
Mrs. R. H. Dorian, 60 Fifth
Mrs. John Farrell, 88 Colonial Rd.
Mrs. Sol Friedberg, 142 Old Stamford Rd., No.
Mrs. Francis Harrison, 49 Hillcrest Ave.
Mrs. Leo Hymovich, 80 Third
Mrs. Arthur Koffler, 90 Glenbrook Rd.
Mrs. David McGourty, 95 Hope
Mrs. Fred A. McGourty, 7 Glenbrook Rd.
Mrs. George Miller McKee, Haviland Rd.
Mrs. Frank C. McMahon, 57 Forrest
Mrs. Edward Malloy, 90 Hubbard Ave.
Mrs. Angelo Mastrangelo, Jr., 19 Grandview Ave.
Mrs. Hugh Miller, Sunset Rd.
Mrs. V. J. Mulaire, 585 Elm
Mrs. Henry J. Murray, West Hill Rd.
Mrs. H. T. McDonald, 19 Bedford Pl.
Mrs. Voyle A. Paul, 62 Standish Rd.
Mrs. J. C. Poczabut, 18 Casr Rd.
Mrs. Samuel A. Rose, 124 Seaton Rd.
Mrs. Charles Sheard, 76 Glenbrook Rd.
Mrs. William Stankard, 140 Forest
Mrs. Jay Ellis Starrett, 970 Summer
Mrs. Oliver Stringfield, 1416 Bedford
Mrs. William D. Troy, 49 St. George
Mrs. Eugene Wrona, 235 South

STRATFORD

Mrs. G. Edward Buda, 40 Yale
Mrs. H. B. Dinan, 3466 Main
Mrs. William A. Geer, 468 Prospect Dr.
Mrs. Crawford Griswold, 3476 Main
Mrs. Chester E. Haberlin, 2944 Main
Mrs. Vincent Lynch, 325 Second Ave.
Mrs. John Maher, 2184 Main
Mrs. B. M. Parmelee, 6080 North Main
Mrs. Sidney Penner, Mt. Pleasant
Mrs. George E. Roberge, 80 Brightwood Ave.

TRUMBULL

Mrs. T. Smith McLean, 80 Oriole Lane
Mrs. R. I. A. Solway, Main

WESTPORT

Mrs. Harry A. DiBlanda, 10 Taylor Pl.
Mrs. David Ellrich, 125 East State
Mrs. William O. Morgan, 193 Main
Mrs. Robert Nespor, Compo Rd.
Mrs. Homer Shoup, Tar Rock Rd.

Hartford County

President	Mrs. Charles Jacobson	45 Wyllys St., Manchester
1st Vice-President	Mrs. Asa Dion	60 Webster Hill Blvd., West Hartford
Membership Chairman	Mrs. Asa Dion	60 Webster Hill Blvd., West Hartford
2nd Vice-President	Mrs. Robert Tennant	156 Walden St., West Hartford
Program Chairman	Mrs. Robert Tennant	156 Walden St., West Hartford
Recording Secretary	Mrs. George Rosenbaum	16 Vardon Rd., West Hartford
Corresponding Secretary	Mrs. William Wawro	10 Braintree Dr., West Hartford
Treasurer	Mrs. Thomas Preston	119 Bainbridge Rd., West Hartford
Assistant Treasurer	Mrs. Robert Osmond	29 Cornell Rd., West Hartford
President-Elect	Mrs. Reginald Edson	24 Chapen St., Windsor
Civilian Defense	Mrs. James Stretch	North Main St., Simsbury
Courtesy	Mrs. Theodore Rosen	Box Mountain Dr., Manchester
Delegate-at-Large	Mrs. Stevens Martin	35 Woodside Circle, Hartford
Directory	Mrs. Christopher McCormack	374 Bloomfield Ave., West Hartford
Finance	Mrs. Alfred Sundquist	98 Princeton St., Manchester
Historian	Mrs. Paul Phelps	R. F. D. 1, Canton Center, Collinsville
Hospitality	Mrs. David O'Keefe	32 Sisson Ave., Hartford
Legislation	Mrs. Theodore Steege	183 Clearfield Rd., Wethersfield
Medical and Surgical Relief	Mrs. Walter Butterfield	26 Saxon Rd., Wethersfield
Memorial Scholarship Fund	Mrs. Norman Barker	Canton Center, Collinsville
Music and Art	Mrs. Sidney Sewall	351 Ridgewood Rd., West Hartford
Publicity	Mrs. John O'Connell	8 Fairlee Rd., West Hartford
Public Relations	Mrs. Walter Butterfield	26 Saxon Rd., Wethersfield
Rummage Sale	Mrs. Holbrook Lowell	296 Wolcott Hill Rd., Wethersfield
School Health	Mrs. Douglas Roberts	R. F. D. 1, Rockville
Telephone	Mrs. Frederick Rogers	123 Ridgewood Rd., West Hartford
Today's Health	Mrs. C. Leonard Smith	3 Spring Lane, West Hartford
Welfare	Mrs. William Doerr	1606 Boulevard, West Hartford

AVON

Mrs. Chester N. Woodford, Deercliff Rd.

BLOOMFIELD

Mrs. Richard Bagnall, Filley
Mrs. Donald J. McCrann, 775 Bloomfield Ave.
Mrs. Maurice Mulville, Box No. 699
Mrs. Frederick Serbin, 17 Simsbury Rd.
Mrs. Bernard Spillane, 251 Simsbury Rd.
Mrs. Benedict Vicas, 20 Grant Hill Rd.

BRISTOL

Mrs. William Furniss, 239 Belridge Rd.
Mrs. David D. Hershey, 189 Lillian Rd.
Mrs. John Papa, Brightwood Rd.
Mrs. Douglas Perry, 155 Louisiana Ave.
Mrs. John Purney, 51 Puritan Rd.
Mrs. Ralph A. Richardson, 40 High
Mrs. Benedict N. Whipple, 85 George
Mrs. Hyman W. Winters, 146 Goodwin

CANTON (COLLINSVILLE)

Mrs. Norman J. Barker, R. F. D. No. 1
Mrs. Gilbert W. Heublein, Old Canton Rd.
Mrs. Paul S. Phelps, R. F. D. No. 1
Mrs. Arthur Unsworth, R. F. D.

EAST HARTFORD

Mrs. Edwin F. Aune, 74 Connecticut Blvd.
Mrs. Roland Z. Carignan, 36 Sunset Ridge Dr.
Mrs. John N. Gallivan, 74 Connecticut Blvd.
Mrs. Zoltan Hervey, 152 Central Ave.
Mrs. Raymond T. Houle, 3 Central Ave.
Mrs. Raymond Lublin, 546 Burnside Ave.
Mrs. Martin P. McCue, 1617 Main
Mrs. John J. Murphy, 118 Holland Lane
Mrs. Harvey H. Sirota, 564 Forrest

EAST WINDSOR HILL

Mrs. Harvey B. Goddard, Station 54½

FARMINGTON

Mrs. Walls W. Bunnell, High
Mrs. Phillip M. Cornwell, Talcott Notch Rd.

GLASTONBURY

Mrs. Edwin M. Griswold, 2858 Main
Mrs. Charles H. Hamlin, 2079 Main
Mrs. Joseph Raffa, 2638 Main

HARTFORD

Mrs. Wilmar M. Allen, 64 Jefferson
Mrs. Harry D. Apter, Hotel Bond
Mrs. Edmund Beizer, 114 Westerly Ter.
Mrs. Kenneth F. Brandon, 128 North Oxford
Mrs. Francis E. Bruno, 566 Prospect Ave.
Mrs. William B. Brewster, 67 Dauntless Lane
Mrs. Aaron Bobrow, 389 Blue Hills Ave.
Mrs. James Bunce, 161 Woodland
Mrs. Sylvester Cappiello, 47 Vine
Mrs. John Carangelo, 402 Farmington Ave.
Mrs. Sidney L. Cramer, 36 Andover
Mrs. Edward H. Crosby, 252 Edgewood
Mrs. Michael J. DeVito, 232 Fairfield Ave.
Mrs. Julian A. Dion, 152 Fairfield Ave.
Mrs. John Donnelly, 341 Washington
Mrs. Rembrandt H. Dunsmore, 3 Niles Park
Mrs. William J. Fay, 162 Collins
Mrs. Fleur C. Foohey, 146 Jefferson
Mrs. James C. Fox, Jr., 43 Forest
Mrs. N. D. Gaines, 232 Farmington Ave.
Mrs. Isidore Geetter, 92 Fern
Mrs. Louis H. Gold, 186 North Beacon
Mrs. Yale Gordon, 789 Maple Ave.
Mrs. James A. Hanaghan, 3 Sterling
Mrs. Manuel S. Hirshberg, 153 Westbourne Pkwy.
Mrs. Perry T. Hough, 179 Beacon
Mrs. Allen Jackson, 210 Tower Ave.
Mrs. James C. Johnson, Jr., 185 North Whitney
Mrs. Dewey Katz, 140 Fern
Mrs. Richard Kay, 134 Dauntless Lane
Mrs. Maurice W. Kearney, 26 Denison
Mrs. Albert R. Keith, 201 North Oxford
Mrs. R. Leonard Kemler, 27 Woodland Pk.
Mrs. Neville Kirsch, 2 Niles Park, Apt. 116, Niles
Mrs. Samuel Mailsen, 159 Ridgefield
Mrs. Frank S. Marino, 16 Coolidge
Mrs. D. Nooman, Markley, 382 Farmington Ave.
Mrs. Alexander Marsh, 67 Coolidge
Mrs. Stevens J. Martin, 35 Woodside Circle
Mrs. John F. McGrath, 65-A Webster
Mrs. T. F. McNulty, 22 North Beacon
Mrs. Harry B. Miller, 20 Colebrook
Mrs. Maurice O'Connell, 234 Terry Rd.
Mrs. David F. O'Keefe, 32 Sisson Ave.
Mrs. V. D. Padula, 1210 Broad
Mrs. Mario P. Rocco, 500 New Britain Ave.
Mrs. Robert L. Rowley, 241 Oxford
Mrs. Leopold St. John, 25 Charter Oak Ave.
Mrs. Abraham M. Schaeffer, 262 Maple Ave.
Mrs. John Shoukimas, 173 Edgewood
Mrs. Pinckney W. Snelling, 99 North Beacon
Mrs. Louis Spektor, 23 Vineland Ter.
Mrs. James Sponzo, 267 Princeton
Mrs. John J. Thomas, 37 Jefferson
Mrs. Morris S. Wineck, 85 Canterbury
Mrs. Dwight R. Wood, 143 Dauntless Lane
Mrs. Norman Zeldis, 135 Andover

KENSINGTON

Mrs. Harry A. Parlato, Lincoln Rd.

MANCHESTER

Mrs. David M. Caldwell, 11 Richard Rd.
Mrs. William L. Conlon, 102 Lakeside Circle
Mrs. Amos E. Friend, 79 Comstock Rd.
Mrs. John B. Hamblet, 212 Henry
Mrs. Charles E. Jacobson, Jr., 45 Wyllys
Mrs. Harold J. Lehmus, 195 Henry
Mrs. Gerard R. Miller, 71 Boulder Rd.
Mrs. Charles H. Peckham, 21 Comstock Rd.
Mrs. Edward J. Platz, 215 Hollister
Mrs. Douglas J. Roberts, R. F. D. No. 1, Rockville
Mrs. Theodore Rosen, Box Mountain Dr.
Mrs. Merrill B. Rubinow, 99 Green Manor Rd.
Mrs. Alfred Sunquist, 98 Princeton
Mrs. E. R. Zaglio, 65 Lakewood Circle

NEW BRITAIN

Mrs. Dwight J. Bernstein, 1 Ten Acre Rd.
Mrs. Carl Edwin Carlson, 26 Wightman Rd.
Mrs. Lewis Chester, 29 Camp
Mrs. Harold M. Clarke, 746 Corbin Ave.
Mrs. Louis W. Daley, 110 Brookside Rd.
Mrs. Sidney Eisenberg, 76 Harrison
Mrs. Francis D. Ellis, 22 West End Ave.
Mrs. Howard Greenblatt, 161 Virginia Ave.
Mrs. Joseph Kalett, 30 Elbridge Rd.
Mrs. Henry Kraszewski, 49 Lexington
Mrs. John C. Larkin, 97 Hart
Mrs. Howard Levine, 80 Bassett
Mrs. William Livingston, 81 Lexington
Mrs. Raymond G. Mainer, 777 Corbin Ave.
Mrs. Joseph A. Mlynarski, 208 South Mountain Dr.
Mrs. Lyle John Monti, 60 Lenox Pl.
Mrs. Philip J. Moorad, 69 Lexington
Mrs. Anthony V. Nevulis, 318 Lincoln
Mrs. Charles G. Paolillo, 108 Harrison Ave.
Mrs. Bernard C. Peck, 32 Park Pl.
Mrs. Edward Resnik, 76 Laurel Rd.
Mrs. Charles T. Schechtman, 62 Dover Rd.
Mrs. Samuel D. Schupack, 32 Mason Dr.
Mrs. Vincent J. Squillacote, 30 Lyle Rd.
Mrs. Charles N. Sullivan, 800 Corbin Ave.
Mrs. Paul Winslow Tisher, 389 Shuttle Meadow Ave.
Mrs. David Waskowitz, 33 Wightman Rd.
Mrs. William J. Watson, 80 Elbridge Rd.
Mrs. Andrew S. Wesoly, 27 Grove Hill
Mrs. John C. White, 115 Vine
Mrs. Mario H. Yanello, 61 McKinley Dr.
Mrs. Henry M. Young, 31 Franklin Sq.

NEWINGTON

Mrs. Francis D. Bowen, 5 Marvis
Mrs. Nicholas Marinaro, Cedarcrest Sanatorium
Mrs. Donald Morrison, 43 Southwood Rd.
Mrs. L. Rogers Morse, Cedarcrest Sanatorium
Mrs. Vincent O'Neill, 72 Southwood Rd.

PLAINVILLE

Mrs. George F. Cook, 71 Farmington Ave.
Mrs. John P. Iannotti, 124 Trumbull Ave.

ROCKY HILL

Mrs. Norman L. Fortier, 543 Main
Mrs. C. Zariphes, 65 Main

SIMSBURY

Mrs. Michael A. Corcoran, Riverside Rd.
Mrs. James E. Stretch, North Main

SOUTHINGTON

Mrs. George M. Gura, 22 Main

SUFFIELD

Mrs. Stephen P. Coates, 328 Main
Mrs. William H. Upson, 172 Main

UNIONVILLE

Mrs. Lionel M. Dawson, 94 Perry
Mrs. Edward T. Dunne, Main

WAREHOUSE POINT

Mrs. Rudolph Maslak, South Main

WEST HARTFORD

Mrs. John C. Allen, 10 Owings Rd.
Mrs. James O. Anderson, 797 Farmington Ave.
Mrs. E. M. Andrews, 20 Sycamore Rd.
Mrs. Louis Antupit, 90 Bainbridge Rd.
Mrs. Harold S. Backus, 20 Vanderbilt Rd.
Mrs. Charles M. Barbour, Wyngate Lane
Mrs. Ronald S. Beckett, 23 Riggs Ave.
Mrs. John T. Beebe, 32 High Farms Rd.
Mrs. Louis Bernstein, 46 Cumberland Rd.
Mrs. Henry L. Birge, 24 Middlefield Dr.
Mrs. Francis J. Braceland, 43 Ledyard Rd.
Mrs. Timothy F. Brewer, 9 Coolridge Rd.
Mrs. C. E. Bruskin, 1769 Ashland Ave.
Mrs. Burdett J. Buck, 153 LaSalle Rd.
Mrs. Richard Buckley, 29 Fulton Pl.
Mrs. Sidney Burness, 280 Steele Rd.
Mrs. John E. Burns, 107 Loomis Dr.
Mrs. Nicholas G. Butler, 21 Robin Rd.
Mrs. David W. Byrne, 93 Sunny Reach Dr.
Mrs. James V. Calio, 3 Kingswood Rd.
Mrs. Robert H. Campbell, 55 North Main
Mrs. Thomas C. Carey, 49 Sycamore Rd.
Mrs. Joseph P. Carson, 41 Woodrow
Mrs. John E. Cartland, Jr., 35 Four Mile Rd.
Mrs. John H. Churchill, 195 Wood Pond Rd.
Mrs. James R. Cullen, 29 Banbury Lane
Mrs. Timothy L. Curren, 14 Braintree Dr.
Mrs. Lawrence A. Cushman, 19 Brunswick Ave.
Mrs. Francis W. Delligan, 44 Webster Hill Blvd.
Mrs. Archibald S. Deming, 173 Sedgwick Rd.
Mrs. Clinton D. Deming, 173 Steele Rd.
Mrs. Thomas H. Denne, 39 North Main
Mrs. Asa J. Dion, 60 Webster Hill Blvd.
Mrs. William J. Doerr, 1606 Boulevard
Mrs. William F. Donovan, 798 Farmington Ave.
Mrs. Walter J. Duksa, 113 Bainbridge Rd.
Mrs. Ralph E. Durkee, Jr., 1564 Boulevard
Mrs. Joseph E. Dushane, 95 Loomis Dr.
Mrs. Reginald C. Edson, 174 Arundel Ave.
Mrs. William A. Ellis, 115 St. Augustine
Mrs. Frederick S. Ellison, 126 Wood Pond Rd.
Mrs. Arthur Emmett, 281 North Main
Mrs. Chester W. Fairlee, Jr., 142 Steele Rd.
Mrs. Victor L. Farland, 59 West Hill Dr.
Mrs. Thomas M. Feeney, 4 Sunset Ter.
Mrs. Edward M. Finesilver, 21 Penn Dr.
Mrs. George Finley, 47 Norwood Rd.
Mrs. Milton C. Fleish, 49 Sulgrave Rd.
Mrs. George F. Fox, 8 Hooker Dr.
Mrs. John Franco, 4 Bainbridge Rd.
Mrs. Henry W. Furniss, 56 Bainbridge Rd.
Mrs. David Galinsky, 96 VanBuren Ave.
Mrs. Lawrence H. Gardy, 166 Ballard Dr.
Mrs. Forrest D. Gibson, 38 Concord
Mrs. Lewis A. Giffin, 16 Belcrest Rd.
Mrs. Charles W. Goff, 1075 North Main
Mrs. Theodore Goldstein, 23 Outlook Ave.
Mrs. William A. Goodrich, 40 Linnard Rd.
Mrs. Gerald S. Greene, 151 Maplewood Ave.
Mrs. Jack Gurwitz, 139 Edgemont Ave.
Mrs. Wendell C. Hall, 84 Brace Rd.
Mrs. Louis D. Harris, 35 Roberts Lane
Mrs. Louis P. Hastings, 29 Paxton Rd.
Mrs. Arthur C. Heublein, 184 Fern
Mrs. Joseph Heyman, Belknap Rd.
Mrs. Curtis B. Hickox, 30 Rosedale Rd.
Mrs. Otto M. Hirschfield, 282 Fern
Mrs. Walter L. Hogan, 68 Rumford Rd.
Mrs. J. Grant Irving, 20 Brookline Dr.
Mrs. Lewis P. James, 39 Walkley Rd.
Mrs. Walter F. Jennings, 60 Riggs Ave.
Mrs. Joseph F. Jenovese. 75 High Farms Rd.
Mrs. Frank S. Jones, 7 Ten Acre Lane
Mrs Richard Karpe, 801 Farmington Ave.
Mrs. George Keefe, 17 Walbridge Rd.
Mrs. Joseph Klein, 15 Norwood Rd.
Mrs. Irving Krall, 50 Pilgrim Rd.
Mrs. F. Earle Kunkel, 33 Mountain Brook Rd.
Mrs. R. Starr Lampson, Thicket Lane, Sunset Farms
Mrs. J. W. Larrabee, 46 Ridgewood Rd.
Mrs. Albert L. Larson, 90 Newport Ave.
Mrs. J. Richard Lenehan, 49 Rosedale Rd.
Mrs. John C. Leonard, 22 Foxcroft Rd.
Mrs. Moses D. Lischner, 3 Lawlor Rd.
Mrs. Leo Litter, 133 Loomis Dr.
Mrs. Milton F. Little, 38 Walbridge Rd.
Mrs. Harry L. F. Locke, 39 Robin Rd.
Mrs. Thomas J. Luby, 40 Bainbridge Rd.
Mrs. Francis L. Lundborg, 35 North Main
Mrs. Morris L. Mancoll, 285 North Quaker Lane
Mrs. Norman M. Mann, 16 Middlefield Dr.
Mrs. John Martin, 3 Arlington Rd.
Mrs. Frank W. McCarthy, 4 Gifford Rd.
Mrs. Christopher McCormack, 374 Bloomfield Ave.
Mrs. Sidney R. McPherson, 145 Clifton Ave.
Mrs. James R. Miller, 7 Banbury Lane
Mrs. Thomas F. Murphy, 30 Blue Ridge Lane
Mrs. Edward Nichols, 12 Vardon Rd.
Mrs. Frederick Nichols, 50 Arnoldale Rd.
Mrs. John O'L. Nolan, 106 Bainbridge Rd.
Mrs. John D. O'Connell, 8 Fairlee Rd.
Mrs. Ralph T. Ogden, 15 Thicket Lane, Sunset Farms
Mrs. Stanley H. Osborn, 41 Brace Rd.
Mrs. Robert H. Osmond, 29 Cornell Rd.
Mrs. Joseph S. Paladino, 31 Bonnyview Dr.

Mrs. Philip F. Parshley, 319 North Quaker Lane
Mrs. Winthrop Partridge, 129 Ridgewood Rd.
Mrs. Albert U. Peacock, 36 Four Mile Rd.
Mrs. Joseph A. Perkins, 159 Sidney Ave.
Mrs. Salvatore Piacente, 10 Frederick Rd.
Mrs. Harold F. Pierce, 583 Park Rd.
Mrs. Maurice M. Pike, 30 Concord
Mrs. Gerald I. Pitegoff, 332 Auburn Rd.
Mrs. William F. Prestley, 8 Cottage Ave.
Mrs. Thomas R. Preston, 119 Bainbridge Rd.
Mrs. L. J. Pyrtek, 112 White Ave.
Mrs. Sidney S. Quarrier, Mountain Rd.
Mrs. Emmet C. Rankin, 59 LeMay
Mrs. Albert J. Robinson, 34 Stratford Rd.
Mrs. David A. Robinson, 79-A Loomis Dr.
Mrs. Frederick P. Rogers, 123 Ridgewood Rd.
Mrs. Samuel D. Rowley, 37 Hilltop Dr.
Mrs. Charles E. Roh, 27 Van Buren Ave.
Mrs. Henry B. Rollins, 16 Pelham Rd.
Mrs. George J. Rosenbaum, 16 Vardon Rd.
Mrs. Ernest Rosenthal, 17 Pine Rd.
Mrs. Frank E. Roth, 37 Sedgewick Rd.
Mrs. Edmund C. Rup, 164 Westland Ave.
Mrs. G. Gardiner Russell, 24 Colony Rd.
Mrs. Joseph N. Russo, 15 Paxton Rd.
Mrs. Francis J. Ryan, 6 Linbrook Rd.
Mrs. Benjamin L. Salvin, 353 North Quaker Lane
Mrs. John Sayers, 573 Park Rd.
Mrs. Peter J. Scafarello, 60 Arnoldale Rd.
Mrs. Siegfried S. Schatten, 32 Arnold Way
Mrs. David H. Schuman, 21 Fulton Pl.
Mrs. William B. Scoville, 334 North Steele Rd.
Mrs. Stewart P. Seigle, 8 Foxridge Rd.
Mrs. Edward J. Sennett, 117 Loomis Dr.
Mrs. Sidney Sewall, 351 Ridgewood Rd.
Mrs. Robert Shreve, 53 High Farms Rd.
Mrs. Jacob B. Sigal, 41 Smallwood Rd.
Mrs. David Slossberg, 153 Penn Dr.
Mrs. C. Leonard Smith, 3 Spring Lane
Mrs. Richard Spillane, 235 South Quaker Lane
Mrs. Welles A. Standish, 168 Wood Pond Rd.
Mrs. Peter J. Steincrohn, 780 Farmington Ave.
Mrs. Lester Q. Stewart, 77 South Main
Mrs. Walter A. Schloss, 36 Middlefield Dr.
Mrs. Ralph W. Storrs, 64 Orchard Rd.
Mrs. Arthur B. Sullivan, 177 Sedgwick Rd.
Mrs. John H. T. Sweet, Jr., 29 Four Mile Rd.
Mrs. John W. Teahan, 121 Loomis Dr.
Mrs. Robert Tennant, 156 Walden
Mrs. Carl L. Thenebe, 4 Walbridge Rd.
Mrs. Hartwell G. Thompson, 184 Mountain Rd.
Mrs. Ralph M. Tovell, 1897 Asylum Ave.
Mrs. Charles A. Tucker, 115 Walbridge Rd.
Mrs. Vincent Turco, 95 Norwood Rd.
Mrs. Charles Von Salzen, 117 Foxcroft Rd.
Mrs. W. H. Van Wart, 1147 Farmington Ave.
Mrs. Carl F. Vernlund, Sunset Farm
Mrs. Charles K. Wallace, 34 Sunset Farm
Mrs. Irving Waltman, 142 Bainbridge Rd.
Mrs. LeRoy H. Wardner, 64 High Farms Rd.
Mrs. N. William Wawro, 10 Braintree Dr.
Mrs. Chester Weed, 127 Four Mile Rd.
Mrs. Julius Weiner, 1119 Trout Brook Dr.
Mrs. Stanley B. Weld, 136 Steele Rd.
Mrs. Benjamin B. Whitcomb, 42 Roberts Lane
Mrs. Benjamin V. White, 19 Chelsea Lane
Mrs. Edward P. White, 41 Riggs Ave.
Mrs. John C. Wienski, 115 Mountain Rd.
Mrs. Benjamin Wiesel, 32 Bainbridge Rd.
Mrs. Archibald C. Wilson, 1909 Boulevard
Mrs. John T. Winters, 19 Linbrook Rd.
Mrs. Frank O. Wood, 5 Sunny Reach Dr.
Mrs. Thacher W. Worthen, 183 Bloomfield Ave.
Mrs. George Wulp, 52 North Quaker Lane
Mrs. Robert M. Yergason, 89 Van Buren Ave.
Mrs. Oscar H. Zarkin, 186 North Main
Mrs. Michael S. Zeman, 165 North Quaker Lane
Mrs. Leon Zimmerman, 1249 Boulevard

WETHERSFIELD

Mrs. John F. Beakey, 36 Golf Rd.
Mrs. Freeman F. Brown, 446 Hartford Ave.
Mrs. Walter L. Butterfield, 26 Saxon Rd.
Mrs. Roger W. Davis, 22 Lincoln Rd.
Mrs. John A. DePasquale, 139 Coleman Rd.
Mrs. Ralph M. Filson, 855 Ridge Rd.
Mrs. Sebastian Giuliano, 270 Wolcott Hill Rd.
Mrs. Carl S. Helijas, 4 River Rd.
Mrs. Eugene E. Lamoureaux, 60 Collier Rd.
Mrs. W. Holbrook Lowell, Jr., 296 Wolcott Hill Rd.
Mrs. Michael C. Messina, 662 Wolcott Hill Rd.
Mrs. F. E. Priddy, 44 State
Mrs. William B. Smith, 91 Center
Mrs. Nicholas E. St. John, 375 Ridge Rd.
Mrs. Theodore W. Steege, 183 Clearfield Rd.
Mrs. Edward H. Truex, Jr., 45 Farmington Rd.
Mrs. Paul H. Twaddel, 430 Church
Mrs. Henry S. Warren, 184 Main
Mrs. John B. Wells, 292 Silas Dean Hwy.
Mrs. Otto G. Wiedman, 265 Wolcott Hill Rd.
Mrs. John H. Woodruff, 122 Garden Court

WINDSOR

Mrs. William H. Horton, 52 Filley
Mrs. Newell Kelly, 101 Palisado Ave.
Mrs. T. M. Poirier, 113 Preston
Mrs. William H. Pomeroy, 1852 Poquonock Ave.
Mrs. Warren Silliman, 26 Prospect

WINDSOR LOCKS

Mrs. Ettore F. Carniglia, 5 North Main

Middlesex County

President	Mrs. Charles Russman	Connecticut State Hospital, Middletown
Vice-President	Mrs. Willard Buckley	Ballfall Rd., Middletown
Secretary	Mrs. Vincent Vinci	Randolph Rd., Middletown
Treasurer	Mrs. Russell Lobb	Deep River
Art	Mrs. Carl Wagner	38 Barlett St., Portland
Child Health	Mrs. Clarence Harwood	Old Mill Rd., Middletown
Civilian Defense	Mrs. Henry Sherwood	Old Mill Rd., Middletown
Hospital Work	Mrs. Mark Thumim	57 South Main St., Middletown
Hospitality	Mrs. Stanley J. Alexander	495 Main St., Portland
Legislation	Mrs. Clair Crampton	158 Mt. Vernon St., Middletown
Medical and Surgical Relief	Mrs. Harry S. Frank	230 Washington St., Middletown

Membership	Mrs. Willard Buckley	Ballfall Rd., Middletown
Nurse Recruitment	Mrs. Louis O. LaBella	Nooks Hill Rd., Cromwell
Parliamentarian	Mrs. Edgar C. Yerbury	Connecticut State Hospital, Middletown
Publicity	Mrs. Vincent Vinci	Randolph Rd., Middletown
Public Relations	Mrs. Walter Nelson	76 Main St., Cromwell
Today's Health	Mrs. Joseph Epstein	28 Church St., Portland

CHESTER

Mrs. D. Leonard Lieberman

CROMWELL

Mrs. Richard Grant, 145 Main
Mrs. Louis O. LaBella, Nooks Hill Rd.
Mrs. Walter Nelson, 76 Main

DEEP RIVER

Mrs. William Tate, Kirtland Rock
Mrs. Russell A. Lobb, 208 Main

EAST HAMPTON

Mrs. Norman Gardner, 22 Summit
Mrs. Louis Soreff, 15 Main

ESSEX

Mrs. F. B. Bradeen, P. O. Box 221
Mrs. Augustus Harris, 60 Main
Mrs. Raymond James, River Road

HIGGANUM

Mrs. Noah Burr, Depot Hill
Mrs. Hazen Calhoun, Main
Mrs. G. Mansfield Craig, Main
Mrs. William Joyce, Main
Mrs. Archibald Thomson, Jr., P. O. Box 394

MIDDLEFIELD

Mrs. Harold Smith, Baileyville

MIDDLETOWN

Mrs. William Bauer, 28 Wall
Mrs. Willard Buckely, Ballfall Rd.
Mrs. Carl C. Chase, 134 Clover
Mrs. Charles B. Chedel, 1511 South Tacoma St., Spokane 9, Washington
Mrs. C. B. Crampton, 158 Mt. Vernon
Mrs. Harry Frank, 230 Washington
Mrs. Julius Grower, 32 Mansfield Ter.
Mrs. Carl C. Harvey, 20 Silver
Mrs. Sanford Harvey, 47 Deerfield Ave., R. F. D. No. 2
Mrs. Clarence W. Harwood, 135 Old Mill Rd.
Mrs. Paul S. Hough, Connecticut State Hospital
Mrs. Harry Knight, 410 Ridge Rd.
Mrs. John L. Korab, 66 South Main
Mrs. Joseph Magnano, 100 Broad
Mrs. Bertram Marks, Coleman Rd.
Mrs. Lloyd Minor, 495 Ridge Rd.
Mrs. Mario Palmieri, 54 Broad
Mrs. Peter Piasta, 145 South Main
Mrs. Hamilton Rinde, Long Hill Rd., c/o R. A. Hubbard
Mrs. Benjamin Roccapriore, 287 Washington Ter.
Mrs. Charles Russman, Connecticut State Hospital
Mrs. Aldo Santiccioli, Connecticut State Hospital
Mrs. Benjamin Shenker, 46 Pine
Mrs. Henry Sherwood, 195 Old Mill Rd.
Mrs. Alfred N. Sweet, 720 Ridge Rd.
Mrs. Mark Thumim, 57 South Main
Mrs. F. Erwin Tracy, 202 Old Mill Rd.
Mrs. Vincent J. Vinci, Randolph Rd.
Mrs. William Wrang, 8 Mazzotta Pl.
Mrs. Edgar Yerbury, Connecticut State Hospital

MOODUS

Mrs. Philip Berwick, Box 268
Mrs. Thomas E. Horsefield

PORTLAND

Mrs. Stanley Alexander, 495 Main
Mrs. Asher Baker, 48 Bartlett
Mrs. Malcolm Blakeslee, 315 Main
Mrs. Jos. Epstein, 28 Church
Mrs. Americo Longo, 344 Main
Mrs. Philip Schwartz, 309 Main
Mrs. Carl Wagner, 39 Bartlett

OLD SAYBROOK

Mrs. Aaron Greenberg, Main

Litchfield County

President	Mrs. Andrew W. Orlowski	64 Belleview Ave., Torrington
Vice-President	Mrs. Sidney Chait	Harwinton Rd., Torrington
President-Elect	Mrs. Daniel Sampson	147 Elm St., Thomaston
Secretary	Mrs. William Murcko	28 Wheeler Lane, Torrington
Treasurer	Mrs. Albert Dautrich	West St., Litchfield
Art	Mrs. Louis Garston	116 Irving Ave., Torrington
Child Health	Mrs. George Cushman	Woodbury
Civilian Defense	Mrs. John Buckley	Goshen
Finance	Mrs. Albert Dautrich	West St., Litchfield
Historian	Mrs. Royal Meyers	59 Hillcrest Ave., Watertown
Legislation	Mrs. Joseph Kott	28 Pearl St., Torrington
Membership and Hospitality	Mrs. Sidney Chait	Harwinton Rd., Torrington
Nurse Recruitment	Mrs. Francis Gallo	11 Monroe St., Winsted
Program	Mrs. Nicholas Samponaro	Prospect St., Litchfield
Public Relations	Mrs. Heinz Markwald	New Hartford
Today's Health	Mrs. Winfield Wight	34 Goodwin Court, Thomaston

CANAAN
Mrs. Forbes Adams, Lower Rd., East Canaan
Mrs. John Elliot, Bragg
Mrs. Robert Sellew, Jr., North Elm
Mrs. Robert Sellew, Sr., West Main

CORNWALL
Mrs. Bradford Walker

GOSHEN
Mrs. John Buckley
Mrs. Victor Conforti
Mrs. Gerald Mitchell
Mrs. A. R. Robertson
Mrs. Francis Sutherland

HARWINTON
Mrs. Arthur Adams

LITCHFIELD
Mrs. Albert W. Dautrich, West
Mrs. Camille H. Huvelle, Beecher Lane
Mrs. Benjamin Katzin, East Litchfield
Mrs. Sidney Kennedy, Jr., Norfolk Rd.
Mrs. John F. Kilgus, West
Mrs. Nicholas Samponaro, Prospect
Mrs. C. Norton Warner, Jr., North
Mrs. Edward Wray, North

NEW HARTFORD
Mrs. H. W. Markwald

NORFOLK
Mrs. R. I. Barstow, Litchfield Rd.
Mrs. Frank Ursone, Greenwood Rd.

TERRYVILLE
Mrs. Mark Coral

THOMASTON
Mrs. Clifford Conklin, 16 Grand
Mrs. Daniel Samson, 147 Elm
Mrs. Winfield Wight, 34 Goodwin Court

TORRINGTON
Mrs. Jack Blinkoff, Torringford West
Mrs. James Canniff, 127 Eno Ave.
Mrs. Sidney A. Chait, New Harwinton Rd.
Mrs. Thomas J. Danaher, 445 Prospect
Mrs. Louis E. Garston, 116 Irving Ave.
Mrs. Michael Giobbe, 102 Pearl
Mrs. Isadore S. Goldberg, 101 Adelaide Ter.
Mrs. Emerson Hill, West View Ter.
Mrs. Gilbert R. Hubert, New Harwinton Rd.
Mrs. Joseph H. Kott, 28 Pearl
Mrs. William J. Murcko, 28 Wheeler Lane
Mrs. Lincoln Opper, 598 East Main
Mrs. Andrew W. Orlowski, 64 Belleview Ave.
Mrs. Frank L. Polito, 24 Church
Mrs. Floyd A. Weed, 50 Forest
Mrs. Winthrop S. Welch, 125 Eastwood Rd.

WASHINGTON
Mrs. Arthur H. Jackson
Mrs. Frederick W. Wersebe

WATERTOWN
Mrs. Wilbur Caney, 429 Main
Mrs. Royal Meyers, 59 Hillcrest Ave.
Mrs. Ellen Reichenbach, 228 Cutler

WINSTED
Mrs. Philip G. Baker, 62 Spencer
Mrs. Francis Gallo, 1 Front
Mrs. Donald W. Herman, 33 Wetmore Ave.
Mrs. Aaron Levy, Wakefield Boulevard
Mrs. Joseph Reidy, 43 Walnut

WOODBURY
Mrs. George Cushman
Mrs. Arthur T. Gillette

New Haven County

President	Mrs. Orvan Hess	Old Orchard Rd., North Haven
President-Elect	Mrs. Clarence Cole	265 Cutler St., Watertown
Vice-President	Mrs. J. David McGaughey, III	146 Fair St., Wallingford
Recording Secretary	Mrs. H. Everest Allen	558 Willow St., Waterbury
Corresponding Secretary	Mrs. Charles S. Culotta	2714 Whitney Ave., Hamden
Treasurer	Mrs. J. Alfred Wilson	1051 East Main St., Meriden
Art	Mrs. Bernard S. Brody	Hilltop Rd., Hamden
Chairman at Large	Mrs. Paul Vestal	Amity Rd., Woodbridge
Christmas Collection for Mental Hospitals	Mrs. Donald Moore	588 Howard Ave., New Haven
Civilian Defense	Mrs. Frank Mongillo	20 Elmwood Rd., New Haven
Finance	Mrs. H. Freeman Pennington	119 Williams St., Meriden
Hospitality	Mrs. Charles Cheney	36 Morse St., Hamden
Legislation	Mrs. J. David McGaughey	146 Fair St., Wallingford
Medical and Surgical Relief	Mrs. Joseph Petrelli	157 East Rock Rd., New Haven
Membership	Mrs. Gustaf Lindskog	50 Marvel Rd., New Haven
Nominating	Mrs. Charles S. Culotta	2714 Whitney Ave., Hamden
Nurse Recruitment	Mrs. Joseph D'Esopo	174 Blake Rd., Hamden
Parliamentarian	Mrs. Creighton Barker	119 Armory St., New Haven
Program	Mrs. Edward Wakeman	Sperry Rd., Bethany
Public Relations	Mrs. James D. Trask	300 Prospect St., New Haven
Publicity	Mrs. M. J. Carl Allinson	133 West Park Ave., New Haven
Co-Chairman	Mrs. Donald Moore	588 Howard Ave., New Haven
Scholarship Fund	Mrs. Joseph D'Esopo Mrs. Stanley Bogunieckí	

School Health	Mrs. William Richards	116 Brook St., Hamden
Telephone	Mrs. Arthur Delgrego	111 Carmalt Rd., Hamden
Today's Health	Mrs. M. Walter Radowiecki	101 Sheldon Ter., New Haven
Volunteer	Mrs. Arthur Wilkinson	950 Ridge Rd., Hamden
Ways and Means	Mrs. Stanley Boguniecki	114 East Main St., Meriden

ANSONIA

Mrs. Michael Aaronson, 134 Jackson
Mrs. Edward Blumenthal, Edgewood Ave.
Mrs. Stephen Ignace, 99 North Cliff
Mrs. John J. Narowski, 116 Hodge Ave.
Mrs. John Renehan, 76 North Cliff

BRANFORD

Mrs. Dana Blanchard, 87 Main
Mrs. Charles Gaylord, 93 South Main
Mrs. Nathan Levy, 49 Wilford Ave.
Mrs. John P. Reisman, Hearthstone, R. F. D. No. 2

CHESHIRE

Mrs. Wilbur Moore, Maple Ave.
Mrs. Edward R. Smith, Johnson Ave.

DERBY

Mrs. George Burns, 42 Seymour Ave.
Mrs. Dominic D'Ambrouso, 46 Atwater
Mrs. Samuel Rentsch, 61 Seymour Ave.
Mrs. Maxon Senfield, 238 Hawthorne Ave.

DEVON

Mrs. Oliver Andrus, 32 Daytona

EAST HAVEN

Mrs. Vincent Balletto, 530 Thompson Ave.
Mrs. Joseph Maiorano, Jr., 195 Hughes
Mrs. Fred Mott, 66 Hotchkiss Rd.
Mrs. Robert Taylor, 578 Thompson Ave.

GUILFORD

Mrs. Winthrop Clarke, Box 43

HAMDEN

Mrs. Irving N. Baer, 40 Gillies Rd.
Mrs. Alexander Bassin, 98 Millbrook Rd.
Mrs. Bernard Brody, Hilltop Rd.
Mrs. Charles Cheney, 36 Morse
Mrs. Louis Claiborn, 64 Blake Rd.
Mrs. Charles Culotta, 2714 Whitney Ave.
Mrs. Arthur L. DelGrego, 111 Carmalt Rd.
Mrs. Clyde Deming, 2 Marshall Rd.
Mrs. Joseph D'Esopo, 174 Blake Rd.
Mrs. Richard B. Elgosin, 2320 Whitney Ave.
Mrs. Malcolm Eveleth, 21 Middle Rd.
Mrs. Alexander Fischer, 18 Helen
Mrs. Lewis Foster, 88 Blake Rd.
Mrs. John Goetsch, 81 Vantage Rd.
Mrs. Samuel Goldberg, Sr., 995 Ridge Rd.
Mrs. Ulysses Golia, 261 Blake Rd.
Mrs. H. Robert Greenhouse, 27 Westview
Mrs. Francis P. Guida, Fennbrook Dr.
Mrs. John C. Healy, Box 81, Mt. Carmel
Mrs. Maurice M. Hillman, 39 Helen
Mrs. Charles Hodgkins, Jr., 365 Ridge Rd.
Mrs. Samuel Jaffe, 35 Rogers Rd.
Mrs. Carl Johnson, 45 Kildeer Rd.
Mrs. Harvey Katz, 22 Beverly Dr.
Mrs. Simon Kleiner, 1042 Whitney Ave.
Mrs. Nicholas LaFemina, 60 Dawes Ave.
Mrs. Marvin Latimer, 1030 Whitney Ave.
Mrs. M. H. Lavorgna, 66 West Helen
Mrs. R. I. Lowenberg, 17 West Helen
Mrs. Herman Little, 171 Sante Fe
Mrs. J. Francis MacNish, 21 Carmalt Rd.
Mrs. Lawrence Michel, 33 West Helen
Mrs. Harry R. Newman, 95 Broadfield Rd.
Mrs. William O'Brien, 32 Hall
Mrs. Wilson Powell, 210 Santa Fe
Mrs. William Richards, 116 Brook
Mrs. William Riordan, 100 Brook
Mrs. Frederick Roberts, 107 Middle Rd.
Mrs. William Ryder, 3 Middle Rd.
Mrs. Daniel Slater, 1100 Dixwell Ave.
Mrs. Morris Slater, 14 West Slope Lane
Mrs. Albert W. Snoke, 210 Millbrook Rd.
Mrs. Emerson L. Stone, 3 Bayberry Rd.
Mrs. Herbert Thoms, 222 Blake Rd.
Mrs. Leopold Trifari, 1087 Whitney Ave.
Mrs. Michael Vegliante, 44 Carmalt Rd.
Mrs. Charles Verstandig, 19 Filbert
Mrs. Charles C. Wilson, 50 Hawley Rd.

MERIDEN

Mrs. Thomas Affinito, 128 West Main
Mrs. Daniel Andrus, Undercliff
Mrs. Donald Badner, 278 Baldwin Ave.
Mrs. Jerome Beloff, 31 Green Rd.
Mrs. Stanley Boguniecki, 114 East Main
Mrs. Sherburne Campbell, 1074 East Main
Mrs. Max Caplan, Hayes
Mrs. William C. Carey, 136 Eaton Ave.
Mrs. David Cohen, 425 Liberty
Mrs. Michael Conroy, 57 William Ave., Bradley Park
Mrs. P. Mason de la Vergne, Undercliff
Mrs. S. F. DeRosa, 29 Cook Ave.
Mrs. George H. Dickinson, Jr., 65 Winthrop Ter.
Mrs. Albert DiGiandomenico, 277 Murray
Mrs. John B. Flynn, 45 Ridgewood Rd.
Mrs. George Fox, 168 Carpenter Ave.
Mrs. Cole B. Gibson, Undercliff
Mrs. James C. Giddings, 221 Carpenter Ave.
Mrs. Frances Guiffrida, 253 Dexter Ave., Ext.
Mrs. Frederick Glike, 917 Broad
Mrs. William E. Hall, 5 Washington Heights
Mrs. Irving Katz, 239 Bradley Ave.
Mrs. Henry Krochmal, 167 Lambert Ave.
Mrs. Jerome A. L'Heureux, 104 Wilcox Ave.
Mrs. Walter Lohrmann, Undercliff
Mrs. Joseph Mekrut, 569 East Main
Mrs. Bernard Mills, 94 East Main
Mrs. Joseph F. Misuk, 111 Hillcrest Ter.
Mrs. Thomas P. Murdock, 19 Windsor Ave.
Mrs. Israel S. Otis, 40 Harvard Ave.
Mrs. Harry Pennington, 119 Williams
Mrs. Louis A. Pierson, 130 Bradley Ave.
Mrs. Raymond V. Quinlan, 36 Winthrop Ter.
Mrs. Samuel Robb, Dexter Ave., Ext.
Mrs. Allen J. Ryan, 63 Bellevue
Mrs. Harold Strickland, 128 West Main
Mrs. Arthur A. Tower, 173 Curtis
Mrs. James S. VanLeuvan, 62 Hillcrest Ter.
Mrs. J. Alfred Wilson, 1051 East Main

MIDDLEBURY

Mrs. John Foster, Porter Hill
Mrs. Joseph Hetzel, Hillsbrow, Breakneck Hill
Mrs. A. A. Johnson, Crest Rd.
Mrs. Alfred Reichenbach, R. F. D. 1
Mrs. Jasper A. Smith, Central Rd.

MIDDLETOWN

Mrs. John Burbank, Atkins, R. F. D.

MILFORD

Mrs. Walter E. Barney, 94 Pt. Lookout
Mrs. William J. H. Fischer, 3 Lafayette
Mrs. Alexander Timm, 101 Captain's Walk

NAUGATUCK

Mrs. D. H. Bluestone, 9 Terrace Ave.
Mrs. William E. Hill, 150 Meadow
Mrs. Charles Kennedy, 14 Hillside Ave.
Mrs. Fred Weile, 270 Church

NEW HAVEN

Mrs. Francis J. Albis, 206 Upson Ter.
Mrs. Jack J. Albom, 159 Diamond
Mrs. Edward P. Allen, 147 Alden Ave.
Mrs. Millard Allen, 65 Dixwell Ave.
Mrs. M. J. Carl Allinson, 133 West Park Ave.
Mrs. Harold Appell, 453 Ellsworth Ave.
Mrs. Creighton Barker, 119 Armory
Mrs. A. William Battista, 111 Osborn Ave.
Mrs. Edmund J. Behan, 2015 Chapel
Mrs. Robert R. Berneike, 44 Benton
Mrs. Courtney Bishop, 9 Austin
Mrs. John A. Bodie, 224 Edwards
Mrs. Elliott Brand, 145 Cleveland Rd.
Mrs. Joseph Bruno, 1266 Forest Rd.
Mrs. Alfonso Capecelatro, 142 Columbus Ave.
Mrs. A. P. Cipriano, 81 Livingston
Mrs. David Clement, 237 East Rock Rd.
Mrs. Samuel Climo, 25 Woodside Ter.
Mrs. William Cohen, 102 Woodside Ter.
Mrs. Harry Conte, 630 Whitney Ave.
Mrs. Robert Cook, 651 Prospect
Mrs. Herman Cutler, 66 Colony Rd.
Mrs. Charles D'Allessio, 523 Yale Ave.
Mrs. Arthur Dayton, 61 Loomis Pl.
Mrs. George B. Darling, 11 Burns
Mrs. William Dennehy, 600 Prospect
Mrs. Frank DiStasio, 251 Edwards
Mrs. Meyer G. Etkind, 1546 Chapel
Mrs. Joseph A. Fiorito, 157 Cleveland Rd.
Mrs. Peter Fiskio, 88 Vista Ter.
Mrs. Barnett Freedman, 322 George
Mrs. Morris Freedman, 46 Oliver Rd.
Mrs. Irving Friedman, 227 McKinley Ave.
Mrs. Mario Garofola, 818 Townsend Ave.
Mrs. Alphonse Gencarelli, 65 Laurel Rd.
Mrs. Angelo Gentile, 640 Townsend Ave.
Mrs. James Gettings, 256 McKinley Ave.
Mrs. Reginald Gillson, 618 Whitney Ave.
Mrs. Morris Goldstein, 451 George
Mrs. Michael L. Gompertz, 210 Yale Ave.
Mrs. Barnett Greenhouse, 1687 Boulevard
Mrs. Joseph Groark, 856 Townsend Ave.
Mrs. Morris Hankin, 1620 Boulevard
Mrs. James C. Hart, 820 Elm
Mrs. Samuel Harvey, 211 Highland
Mrs. H. Thomas Hersey, 105 Gilnoc Dr.
Mrs. Clayton Hitchins, 599 Whitney Ave.
Mrs. Gabriel Ingenito, 400 Whitney Ave.
Mrs. Harry E. Klebanoff, 40 Alston Ave.
Mrs. William B. Koufman, 275 West Elm
Mrs. Morris Krosnick, 119 West Park Ave.
Mrs. Samuel D. Kushlin, 655 Whitney Ave.
Mrs. Maxwell Lear, 551 Ellsworth Ave.
Mrs. Frank E. Lach, 105 Greenhill Ter.
Mrs. Hyman Levin, 168 Linden
Mrs. Daniel Levy, 81 McKinley Ave.
Mrs. Robert Lewis, 52 Trumbull
Mrs. Gustaf Lindskog, 50 Marvel Rd.
Mrs. Carter Marshall, 215 Lake View Ter.
Mrs. Harry Maynard, 882 Howard Ave.
Mrs. Paul McAlenney, 45 Cleveland Rd.
Mrs. William Mendelsohn, 170 Linden
Mrs. S. R. Millen, 543 Dixwell Ave.
Mrs. Frank Mongillo, 20 Elmwood Rd.
Mrs. Donald Moore, 588 Howard Ave.
Mrs. Luther Musselman, 192 Livingston
Mrs. Louis Nahum, 85 Loomis Pl.
Mrs. Louis O'Brasky, 530 Ellsworth Ave.
Mrs. Denis O'Connor, 239 Edwards
Mrs. Orlando Pellicia, 183 Livingston
Mrs. Joseph Petrelli, 157 East Rock Rd.
Mrs. Samuel Philipson, 665 Ellsworth Ave.
Mrs. Pasquale Piccolo, 508 Yale Ave.
Mrs. Charles Pitegoff, 170 Ray Rd.
Mrs. David Poverman, 116 McKinley Ave.
Mrs. Grover F. Powers, 167 Armory
Mrs. M. Walter Radowiecki, 101 Sheldon Ter.
Mrs. Morris Rothschild, 10 Marvel Rd.
Mrs. Alan Rozen, 423 Fountain
Mrs. Walter Russell, 139 Alston Ave.
Mrs. Joseph Russo, 255 Edwards
Mrs. William Salter, 178 Cold Spring
Mrs. Charles Scholhamer, 116 Avon
Mrs. Robert Seabury, 58 Trumbull
Mrs. Milton J. Senn, 972 Prospect
Mrs. Peter Serafin, 809 State
Mrs. A. Lewis Shure, 42 Birch Dr.
Mrs. Harry Sigel, 195 Livingston
Mrs. Samuel Silverberg, 140 Laurel Rd.
Mrs. Frederick Smith, 84 Dixwell Ave.
Mrs. Samuel Spinner, 36 Sherman Ave.
Mrs. Harry Stewart, 33 Pendleton
Mrs. Maurice Strauss, 18 Everitt
Mrs. Morgan Swirsky, 280 McKinley Ave.
Mrs. Max Taffel, 174 Cooper Pl.
Mrs. James D. Trask, 300 Prospect
Mrs. J. A. VanHeuvan, 154 Armory
Mrs. Harry Wagenheim, 500 Prospect
Mrs. Arthur Weil, 307 St. Ronan
Mrs. Sidney Winters, 170 McKinley Ave.
Mrs. Raymond Zagraniski, 977 Whalley Ave.

NORTH HAVEN

Mrs. Benedict Biondi, 570 Skiff
Mrs. Eugene Blake, Blue Hills Rd.
Mrs. Orvan Hess, Old Orchard Rd.
Mrs. Louis Jack, 1415 Ridge Rd.
Mrs. Robert Jordan, Old Orchard Rd.
Mrs. E. J. Marsh, 25 Cooper Rd.
Mrs. James McKeon, 566 Skiff
Mrs. Joseph Mignone, 1477 Ridge Rd.
Mrs. Maxwell Pasternack, 55 Marlborough Rd.
Mrs. Sterling Taylor, 1 St. John

ORANGE
Mrs. Mario Conte, Orange Center Rd.
Mrs. Lawrence Lydon, Great Oak Rd.
Mrs. Charles Petrillo, Farview Acres, Derby Ave.
Mrs. Melchior Savarese, Box 260, Derby Ave.

WALLINGFORD
Mrs. John Carrozella, 35 So. Main
Mrs. J. T. Ferguson, Jr., Mansion Rd.
Mrs. Frank Konopka, 6 So. Whittlessey Ave.
Mrs. J. David McGaughey, III, 146 Fair
Mrs. W. Haviland Morriss, Gaylord Farm
Mrs. Kurt Pelz, 26 So. Main
Mrs. Mark Sheehan, 245 Center

WATERBURY
Mrs. H. Everett Allen, 558 Willow
Mrs. Theodore Bevans, 165 Fiske
Mrs. Orpheus Bizzozero, Country Club Rd.
Mrs. Rudolf Blau, 47 Cooke
Mrs. Abe S. Brown, 110 Avalon Circle
Mrs. Thomas Cottiero, 21 Cooke
Mrs. Rudolf Daniani, 5 Cooke
Mrs. Alfred E. Dreher, 292 Gaylord Dr.
Mrs. John Freheit, 85 Grove
Mrs. Jacques Green, 192 Euclid Ave.
Mrs. Michael Gualtieri, 55 Forest Ridge Rd.
Mrs. Albert Herrman, 142 Robinwood Rd.
Mrs. Milton Jennes, 277 Columbia Blvd.
Mrs. Sidney Jennes, 92 Country Club Rd.
Mrs. Edward Kirschbaum, 55 Eastfield Rd.
Mrs. Frederick LaBrecque, 132 Columbia Blvd.
Mrs. Norman C. Margolius, 1 Eastfield Rd.
Mrs. Harold Morrill, 300 W. Main
Mrs. Elliott R. Mayo, 129 Prospect
Mrs. Irving Platt, 45 Prospect
Mrs. Robert Pollard, 76 Euclid Ave.
Mrs. Henry J. Stettbacher, 58 Concord
Mrs. Jos. Sklaver, 310 Pine
Mrs. Evan J. Whalley, 174 E. Mountain Rd.
Mrs. Frederick Zarkowitz, 1803 E. Main
Mrs. Seymour I. Zonn, 36 Holmes Ave.
Mrs. Reuben Zucker, 117 Lexington Ave.

WATERTOWN
Mrs. Clarence Cole, 265 Cutler
Mrs. Jos. D. Collins, 326 Woodbury Rd.
Mrs. Robert Davie, Longview Ave.
Mrs. J. Harold Root, Thomaston Rd., Box 137
Mrs. Chris Neuswanger, 64 Hillcrest Ave.

WEST HAVEN
Mrs. W. L. W. Glenn, 685 Forest Rd.
Mrs. Frederick Kessler, 233 Elm
Mrs. Leo W. Koster, 381 Main
Mrs. N. A. Milano, 271 Elm
Mrs. John J. Milici, 354 Campbell Ave.
Mrs. William O'Connell, 295 Main
Mrs. Anthony Parisi, 131 Elm
Mrs. Abraham Vinograd, 1225 Campbell Ave.

WOODBRIDGE
Mrs. Gervase J. Connor, Beecher Rd.
Mrs. Clement Clarke, Amity Rd.
Mrs. Eugene Clifton, Amity Rd.
Mrs. Averill Liebow, North Racebrook Rd.
Mrs. William German, Johnson Rd.
Mrs. Arthur Geiger, Amity Rd.
Mrs. Stephen Magyar, Burma Rd.
Mrs. William Perham, Amity Rd.
Mrs. Paul Vestal, Amity Rd.
Mrs. Arthur Yudkin, Tallwood Rd.

WOODMONT
Mrs. George Goldman, 195 New Haven Ave.

YALESVILLE
Mrs. Henry Caplan, Main

New London County

President	Mrs. Martin L. O'Neill	Tift St., Jewett City
President-Elect	Mrs. Aloys Ansprenger	Mason Island, Mystic
Secretary	Mrs. Victor Smilgin	265 Williams St., New London
Corresponding Secretary	Mrs. Joseph Wool	803 Montauk Ave., New London
Treasurer	Mrs. Henry Archambault	2 North Second Ave., Taftville
Art	Mrs. Edward Comstock	Starr Hill Rd., Groton
Finance	Mrs. Frederick Hartman	Glenwood Park, New London
	Mrs. William Wener	22 Harland Pl., New London
Historian	Mrs. John Martin	153 West Thames St., Norwich
Hospitality	Mrs. Louis Guss	100 Rollins St., Norwich
	Mrs. Julian Ely	R. F. D. 2, Lyme
Legislation	Mrs. C. M. Krinsky	951 Ocean Ave., New London
Membership	Mrs. S. P. Tombari	Seaside Sanatorium, Waterford
	Mrs. David Rousseau	286 Hamilton Ave., Norwich
Medical and Surgical Relief	Mrs. Ward McFarland	317 Ocean Ave., New London
Nurse Recruitment and Welfare	Mrs. Sidney Drobnes	Harland Rd., Norwich
	Mrs. Milton Fabricant	275 Montauk Ave., New London
Program	Mrs. Aloys Ansprenger	Mason Island, Mystic
Public Relations	Mrs. Anthony Loiacono	291 Vauxhall St., New London
	Mrs. Kutt Oppenheimer	5 Julian St., Norwich
Publicity	Mrs. John Supliki	40 Slater Ave., Norwich
	Mrs. Frederick Goodrich	625 Ocean Ave., New London
School Health	Mrs. Joseph Mahoney	Ox Hill Rd., Norwich
Telephone	Mrs. John Woodward	Hillside Rd., New London
	Mrs. Gerald Carroll	Norwich
Today's Health	Mrs. Frederick Barrett	5 South Main St., Jewett City

COLCHESTER
Mrs. Irving Friedman, 16 Norwich Ave.

GROTON
Mrs. Edward Comstock, Starr Hill Rd.
Mrs. E. L. Douglas, 198 Thames
Mrs. Erich Goldmeier, 306 Thames
Mrs. Duncan MacDougall, 42 Ramsdell
Mrs. Emile Szlemko, 27 Poquonnock Rd.

JEWETT CITY
Mrs. Frederick C. Barrett, 5 South Main
Mrs. Martin O'Neil, Tift

LYME
Mrs. Julian Ely, R. F. D. No. 2
Mrs. Harold VonGlahn, Ferry Rd., Old Lyme

MYSTIC
Mrs. Aloys Ansprenger, Mason Island
Mrs. B. B. Crandall, 31 Gravel
Mrs. Wm. Edmonston, 31 New London Rd.
Mrs. Roger Fowler, 21 E. Main
Mrs. E. Roland Hill, 43 E. Main

NIANTIC
Mrs. Frederick Dey, Smith
Mrs. H. W. Duennebier, Lincoln Ave.

NEW LONDON
Mrs. Joseph Becker, 2 Henderson Rd.
Mrs. Ross E. Black, 305 Montauk Ave.
Mrs. Eric Blank, 36 Shirley Lane
Mrs. John Brosnan, 223 Glenwood Ave.
Mrs. Louis DeAnglis, 193 Montauk Ave.
Mrs. Charles D. Dyer, 102 Montauk Ave.
Mrs. Malcolm Ellison, 334 Montauk Ave.
Mrs. Milton Fabricant, 275 Montauk Ave.
Mrs. Frederick Fagan, 61 Fair Harbor Pl.
Mrs. Jos. Ganey, 81 Plant
Mrs. John J. Gager, Old Norwich Rd., Quaker Hill
Mrs. Edward Gipstein, 175 Parkway
Mrs. Frederick Hartmann, Glenwood Park
Mrs. I. Hendel, 336 Pequot Ave.
Mrs. Frederick Goodrich, 625 Ocean Ave.
Mrs. Harold Irwin, 158 Williams
Mrs. Saul Karpel, 275 Glenwood Ave.
Mrs. C. Kauffman, 16 Jerome Court
Mrs. Charles M. Krinsky, 951 Ocean Ave.
Mrs. Anthony Loiancano, 291 Vauxhall
Mrs. Richard Loiancano, 105 Norwood Ave.
Mrs. Ward McFarland, 833 Ocean Ave.
Mrs. Thomas Murray, 906 Montauk Ave.
Mrs. Thomas Murray, Jr., 319 Vauxhall
Mrs. Tage Neilson, 571 Ocean Ave.
Mrs. Robert Olsen, 802 Ocean Ave.
Mrs. Stewart Owre, Chapel
Mrs. Philip Savage, 203 Ledyard
Mrs. Victor Smilgin, 265 Williams
Mrs. Hilliard Spitz, 17 Henderson Rd.
Mrs. James Sturtevant, Hillside Rd.
Mrs. Morris Sulman, 14 Greenway
Mrs. Hill Warren, 164 Hempstead
Mrs. Harold Wellington, 2 Worthington Rd.
Mrs. Carl H. Weis, 756 Pequot Ave.
Mrs. Joseph Wool, 803 Montauk Ave.
Mrs. Joseph Woodward, Hillside Rd.

NORWICH
Mrs. Arthur Acy, 51 Flyers Drive
Mrs. Mario Albamonti, 46 Rockwell
Mrs. H. A. Bergandahl, Huntington Lane, Norwichtown
Mrs. G. Bielecki, 40 Harland Pl.
Mrs. Hugh Campbell, 11 Broad
Mrs. Gerald Carrol, 11 Lincoln Ave.
Mrs. Sidney Drobnes, Harland Rd.
Mrs. M. A. Ferrera, Uncas-on-Thames
Mrs. George Gildersleeve, 100 Harland Rd.
Mrs. Louis Guss, 10 Robbins Ct.
Mrs. H. W. Higgins, 55 Sachem Ter.
Mrs. Morris Katz, 46 Western Ave.
Mrs. Winfield Kelley, Uncas-on-Thames
Mrs. R. H. Kettle, Norwich State Hospital
Mrs. Arnaud LaPierre, 431 Washington
Mrs. Warren La Pierre, 32 Clinton Ave., Norwichtown
Mrs. Benjamin Lord, 23 Williams St.
Mrs. Joseph Mahoney, Ox Hill Rd.
Mrs. John Martin, 153 W. Thames
Mrs. Maurice Moore, R. F. D. No. 6, Laurel Hill
Mrs. Kurt Oppenheimer, 5 Julian
Mrs. Nicholas Philips, Montgomery Lane
Mrs. Gilbert Quintiliani, Williams
Mrs. John C. Raymer, 26 Carroll Ave.
Mrs. David Rousseau, 60 Broad
Mrs. Peter Schwartz, 281 Broadway
Mrs. Lewis Sears, 14 Julian
Mrs. Solam Segel, Harland Rd.
Mrs. John Suplicki, 40 Slater Ave.
Mrs. David Sussler, 34 Rockwell
Mrs. Clarence Thompson, Canterbury Tpke.
Mrs. Howard Turner, Uncas-on-Thames
Mrs. William Wener, 22 Harland Pl.
Mrs. George Wilson, Uncas-on-Thames

STONINGTON
Mrs. Henry Haines, North Rd.
Mrs. William Veal, 99 Water

TAFTVILLE
Mrs. Henry Archambault, 2 North Second Ave.

UNCASVILLE
Mrs. Jacob Lubchansky, Lower Starr Rd.

WATERFORD
Mrs. Robert Henkle, Pepper Box Hill
Mrs. Walter Lukoski, Seaside Sanatorium
Mrs. C. John Satti, Oswegatchie
Mrs. Richard Starr, Best View
Mrs. S. Paul Tombari, Seaside Sanatorium

Windham County

President	Mrs. Frederick A. Bearsdley	Columbia
President-Elect	Mrs. Robert Dinolt	119 Prospect St., Putnam
Secretary	Mrs. William S. Maurer	159 Prospect St., Willimantic
Treasurer	Mrs. Karl T. Phillips	36 Church St., Putnam
Historian	Mrs. Morton Arnold	Windham
Legislation	Mrs. E. J. Ottenheimer	Windham
Medical and Surgical Supplies	Mrs. James Anderson	Windham
Nurses' Scholarship	Mrs. Moses Margolick	Genevieve St. Ext., Putnam
Program	Mrs. Robert Dinolt	119 Prospect St., Putnam
Publicity and Press	Mrs. James Major	Scotland
Revisions	Mrs. Ralph Gilman	Storrs
School Health	Mrs. Winston Hainsworth	Windham
Today's Health	Mrs. W. M. Shepard	R. F. D. 1, Putnam
Ways and Means	Mrs. Angelo Gulino	Plainfield

ABINGTON
Mrs. Bruce R. Valentine

COLUMBIA
Mrs. Frederick A. Beardsley, Jr.

COLUMBIA LAKE
Mrs. Sawyer E. Medbury

DANIELSON
Mrs. Gerard M. Chartier, 148A Main
Mrs. Cecil R. Garcin, 11 Broad
Mrs. James Franklyn Jones, 1 Broad
Mrs. Andrew O. Laakso, 213 No. Main
Mrs. Warren A. Tanner, 36 Academy

HAMPTON
Mrs. Arthur D. Marsh, Box 65

MANSFIELD CENTER
Mrs. Kenneth K. Kinney

MANSFIELD DEPOT
Mrs. Neil A. Dayton, Box 51
Mrs. Joseph E. Nowrey, Box 51

MOOSUP
Mrs. John A. Woodworth

NORTH GROSVERNORDALE
Mrs. Sherman L. Waldron, Woodstock Rd.

NORTH WINDHAM
Mrs. Richard V. Newcombe, Box 107
Mrs. Walter Rowson, Jr.

PLAINFIELD
Mrs. E. Arthur Barry
Mrs. Angelo J. Gulino

PUTNAM
Mrs. Robert Dinolt, 119 Prospect
Mrs. Leo G. LaPalme, R. F. D. No. 2
Mrs. Moses Margolick, Genevieve Ext.
Mrs. Karl T. Phillips, 36 Church
Mrs. William M. Shepard, R. F. D. No. 1

STORRS
Mrs. Ralph L. Gilman, Willowbrook Rd.

WEST WILLINGTON
Mrs. Franklin M. Goodchild

WILLIMANTIC
Mrs. Edwin H. Basden, 281 Church
Mrs. Joseph A. Girouard, 250 Pleasant
Mrs. James W. Major, R. F. D. No. 2, Windy Hill
Mrs. William S. Maurer, 159 Prospect
Mrs. Reuben Rothblatt, 8 Willard
Mrs. Nathan Spector, 59 Church

WINDHAM CENTER
Mrs. James T. Anderson
Mrs. Morton Arnold
Mrs. Conrad S. Baker
Mrs. George H. Carter
Mrs. Winston C. Hainsworth
Mrs. Edward J. Ottenheimer

WOODSTOCK
Mrs. David H. Bates
Mrs. George C. Lincoln

Members At Large

ROCKVILLE
Mrs. Roy Ferguson

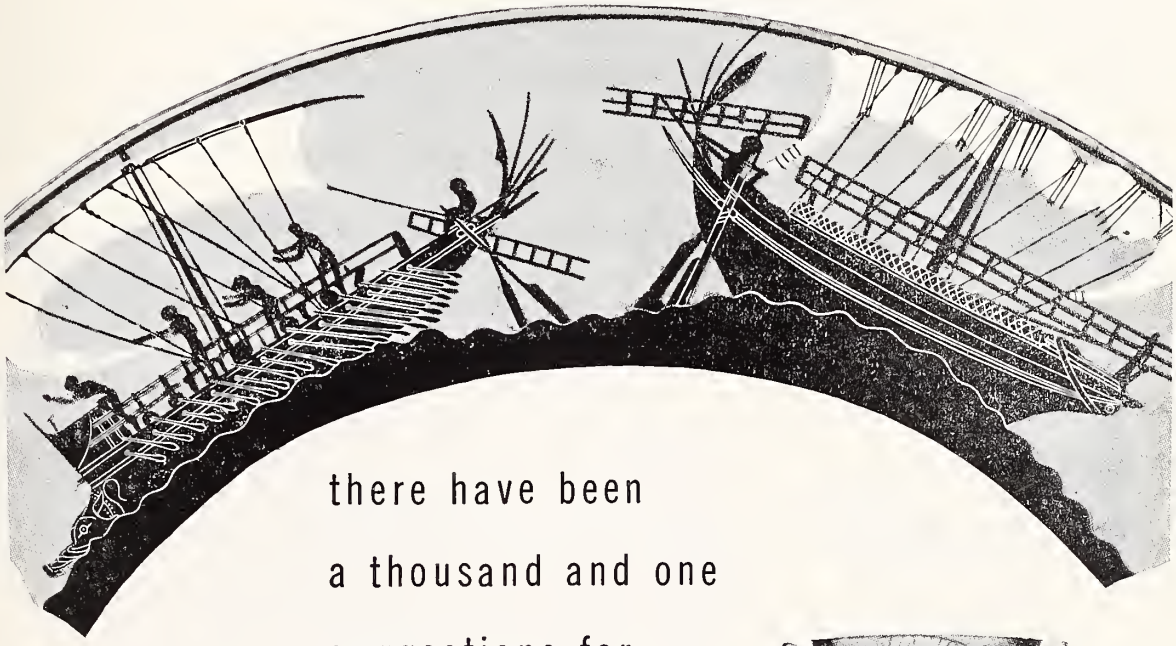
SOMERS
Mrs. Ralph B. Thayer

YOUR VOTE IS VITAL!

Whatever Your Party - - - REGISTER!

Whoever Your Choice - . - - VOTE!

Ever since man went down
to the sea in ships



there have been
a thousand and one
suggestions for
the relief of
motion sickness.



War ship and merchant ship, about 500 B. C.; from painted vase found at Vulci in Etruria, now in the British Museum.

Now, relief from this age-old malady with

DRAMAMINE®

BRAND OF DIMENHYDRINATE

Available as: Tablets—50 mg.
Liquid—12.5 mg. per 4 cc.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SPECIAL NOTICES

CONNECTICUT POSTGRADUATE SEMINAR IN PSYCHIATRY AND NEUROLOGY

The Sixth Connecticut Postgraduate Seminar in Psychiatry and Neurology will begin its courses of lectures on October 1, 1952 and will continue through May 4, 1953.

From October 1 through December 12, 1952 sessions in clinical neurology, neuroroentgenology, electroencephalography, neuroanatomy, neurophysiology, neuropathology, and review and demonstrations in neuroanatomy and neuropathology will be held on Mondays and Wednesdays from 4:00 P. M. to 9:30 P. M. at Yale University School of Medicine, New Haven.

On Mondays, from January 5 through March 2, 1953 from 4:00 to 9:30 P. M., courses in clinical psychology, general psychopathology, psychiatric syndromes, therapy, psychosomatic medicine, geriatric psychiatry, and psychiatry and law will be held at the Connecticut State Hospital.

From March 9 through March 30, 1953 (Mondays), from 4:00 to 9:30 P. M., a course in child psychiatry will be held at the Child Study Center of Yale University, New Haven; and a course in pediatric neurology will be held from April 6 through May 4, 1953 at Yale University School of Medicine, New Haven, from 6:30 to 9:45 P. M.

There are no fees for the above courses.

Copies of the program may be obtained from the Office of the Assistant Dean for Postgraduate Medical Education, Yale University School of Medicine, 333 Cedar Street, New Haven.

PROGRAM, AMERICAN MEDICAL WRITERS' ASSOCIATION MEETING, ST. LOUIS, OCTOBER 1, 1952

The 9th Annual Meeting, American Medical Writers' Association, will be held at the Jefferson Hotel, St. Louis, the afternoon and evening of Wednesday, October 1, under the presidency of Arkell M. Vaughn, M.S., M.D., F.A.C.S., Chicago, Clinical Associate Professor of Surgery, Loyola University. The meeting will be held during the 17th Annual Meeting of the Mississippi Valley Medical Society (October 1, 2, 3) at the same hotel. The program is as follows:

The afternoon program will be a Symposium on Medical Writing conducted by J. Linwood Cutler, B.S., M.A., Columbia, Mo., of the University of Missouri School of Journalism; Walter C. Alvarez, M.S., M.D., F.A.C.P., Chicago, Editor-in-Chief, *Modern Medicine;* Theodore Peterson, B.A., M.S., Urbana, Ill., of the University of Illinois School of Journalism and Communications; Harold Swanberg, B.S., M.D., F.A.C.P., Quincy, Ill., Editor, *Mississippi Valley Medical Journal.* The discussion will be led by Vincent T. Williams, M.D., F.A.C.S., Kansas City, Mo., Editor-Elect, *Journal of Missouri State Medical Association,* and John Rice Miner, B.A., SC.D., Rochester, Minn., Section of Publications, Mayo Clinic.

The evening program will consist of a Cocktail Party, compliments of the C. V. Mosby Co., St. Louis; Dinner; presentation of Association Awards and Fellowships and an address on "Wanted More Lay Medical Writers" by W. W. Bauer, B.S., M.D., Chicago, Editor of *Today's Health* (published by the AMA). A detailed program may be secured from the Secretary, Harold Swanberg, M.D., W.C.U. Bldg., Quincy, Ill. All concerned with medical writing, journalism, or publishing are cordially invited and urged to attend. There are no registration fees.

PROGRAM, MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING, ST. LOUIS OCTOBER 1, 2, 3, 1952

The 17th Annual Meeting, Mississippi Valley Medical Society, will be held at the Jefferson Hotel, St. Louis, October 1, 2, 3, under the presidency of Daniel L. Sexton, M.D., F.A.C.P., Assistant Professor of Internal Medicine, St. Louis University. The meeting will be held during the 9th Annual Meeting of the American Medical Writers' Association (October 1) at the same hotel. There will be 37 clinical teachers on the program including the following: Drs. Edward J. McCormick, Toledo, O.; Philip S. Hench, Rochester, Minn.; Phillippe V. Cardon, Jr., New York; Keith S. Grimson, Durham, N. C.; Wallis L. Craddock, Salt Lake City; Charles C. Dennie, Kansas City, Mo.; James F. Bishop, Davenport, Iowa, Thomas F. Thornton, Waterloo, Iowa; Robert G. Carney and Robert N. Newman, Iowa City, Iowa; Harry Oberhelman, Wright Rowe Adams, Frederich H. Falls, Walter C. Alvarez, John F. Sheehan, Leo M. Zimmerman, William M. Lees, Harley E. Cluxton, Jr., and Leo P. A. Sweeney of Chicago; J. William Thompson, Grayson Carroll, Robert W. Bartlett, Carl Mayer, Julius Jensen, Henry A. Schroeder, Ralph A. Kinsella, Joseph A. Hardy, Jr., Goronwy O. Broun, William G. Klingberg, William H. Olmsted, C. Rollins Hanlon, Arthur E. Strauss, Paul Murphy, W. Barry Wood, Carl V. Moore, William A. Knight, Jr., and Willard M. Allen of St. Louis.

There will be three full days of scientific meetings, the entire program being especially arranged to appeal to general practitioners. The meeting will include a large Technical and Scientific Exhibit Hall, Noon Round Table Luncheons, Fellowship Hour and Banquet. All ethical physicians are cordially invited to attend. There are no registration fees. A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., W. C. U. Building, Quincy, Illinois.

IN FALL ALLERGIES . . .

Turn Distress into Comfort

Time-tested therapy with NEO-ANTERGAN* turns malaise into comfort for patients suffering from ragweed pollens.

Neo-Antergan brings safe symptomatic relief quickly by effectively blocking the histamine receptors.

Promoted exclusively to the profession, Neo-Antergan is available only on your prescription.

Your local pharmacy stocks Neo-Antergan Maleate *in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.*



The Physician's Product

Neo-Antergan®

MALEATE

(PYRILAMINE MALEATE, MERCK)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.

Manufacturing Chemists

RAHWAY, NEW JERSEY

© 1952—Merck & Co., Inc.

BOARD OF CLINICAL CHEMISTRY

The American Board of Clinical Chemistry, Inc., has, by amending the By-Laws, extended the period during which the Board will review applications for Certifications of Clinical Chemists without examination, from July 1, 1952 to December 31, 1952. Applications filed before the December date will be considered by the Board at subsequent meetings.

The Board also authorized publication of a list of those presently certified. This list is expected to be available from the secretary about September 1, 1952.

The fee for each application form was increased from $1 to $3, which will only partly defray the office expense involved in handling these forms. The application forms may be obtained from Joseph W. E. Harrisson, SC.D., secretary-treasurer, American Board of Clinical Chemistry, Inc., 1921 Walnut St., Philadelphia 3, Penna., upon forwarding the fee and the name of the applicant as it is to be recorded.

ARMY MEDICAL SERVICE OFFERS 17 POST-GRADUATE COURSES FOR MILITARY AND CIVILIAN PHYSICIANS

The Army Medical Service will conduct 17 short post-graduate courses in surgery, psychiatry and other subjects of major medical importance during the last six months of 1952.

The instruction is open to both military and civilian physicians and is the broadest program of postgraduate professional training of this type ever sponsored by the Army Medical Service. The courses will be given at six large Army teaching hospitals and the Armed Forces Institute of Pathology in Washington, D. C.

Instruction will be offered in the following subjects: arthritis and allied diseases; current trends in internal medicine; internal medicine, clinical electrocardiography and conference on heart disease; pathology of ionizing radiation injuries; forensic pathology; clinical pathology; exfoliative cytology and cancer detection; physical medicine; psychotherapeutic medicine; pulmonary diseases; radiology, tumor surgery; physiological considerations in general surgery; and surgery.

Applications from Army medical officers on active duty and full time Civil Service physicians at Army installations should be forwarded to the Office of the Surgeon General, Department of Army, Washington 25, D. C., Attention: Career Management Branch, Personnel Division. They should be received six weeks prior to the opening date of the course.

Reserve medical officers should apply to their Army area commander, while National Guard physicians should write the National Guard Bureau in Washington. Civilian physicians in the Federal service or in private practice should apply to the appropriate hospital or installation commander.

SEPTEMBER DATES SET FOR MEDICAL PR INSTITUTE

September 4 and 5 are the dates set for the first Medical Public Relations Institute, which will be held at the Edgewater Beach hotel in Chicago.

It will be a workshop-type conference at which public relations personnel can get practical information on the day-by-day operation of a medical PR program.

The institute, primarily for lay public relations employees of state and county medical societies, will supplement the annual Medical Public Relations Conference which will be held December 1—just prior to the AMA Clinical Session in Denver.

ANNUAL MEETING NEW HAMPSHIRE AND VERMONT SOCIETIES

The joint annual meeting of the New Hampshire Medical Society and the Vermont State Medical Society will be held at the Mt. Washington Hotel, Bretton Woods, N. H., September 7, 8 and 9, 1952. AMA President Louis H. Bauer will be one of the speakers.

THE DOCTOR'S OFFICE

Donald G. Arnault, M.D., formerly of Hanover, N. H., has opened an office for the practice of general surgery at 96 South Main Street, Middletown.

Charles T. Bingham, M.D., has resumed the private practice of medicine at 576 Farmington Avenue, Hartford.

Glover E. Howe, Frank O. Wood, Paul R. Johnson, Leroy H. Wardner and Dwight R. Wood announce the association of Robert C. Emmel in the practice of obstetrics and gynecology at 85 Jefferson Street, Hartford.

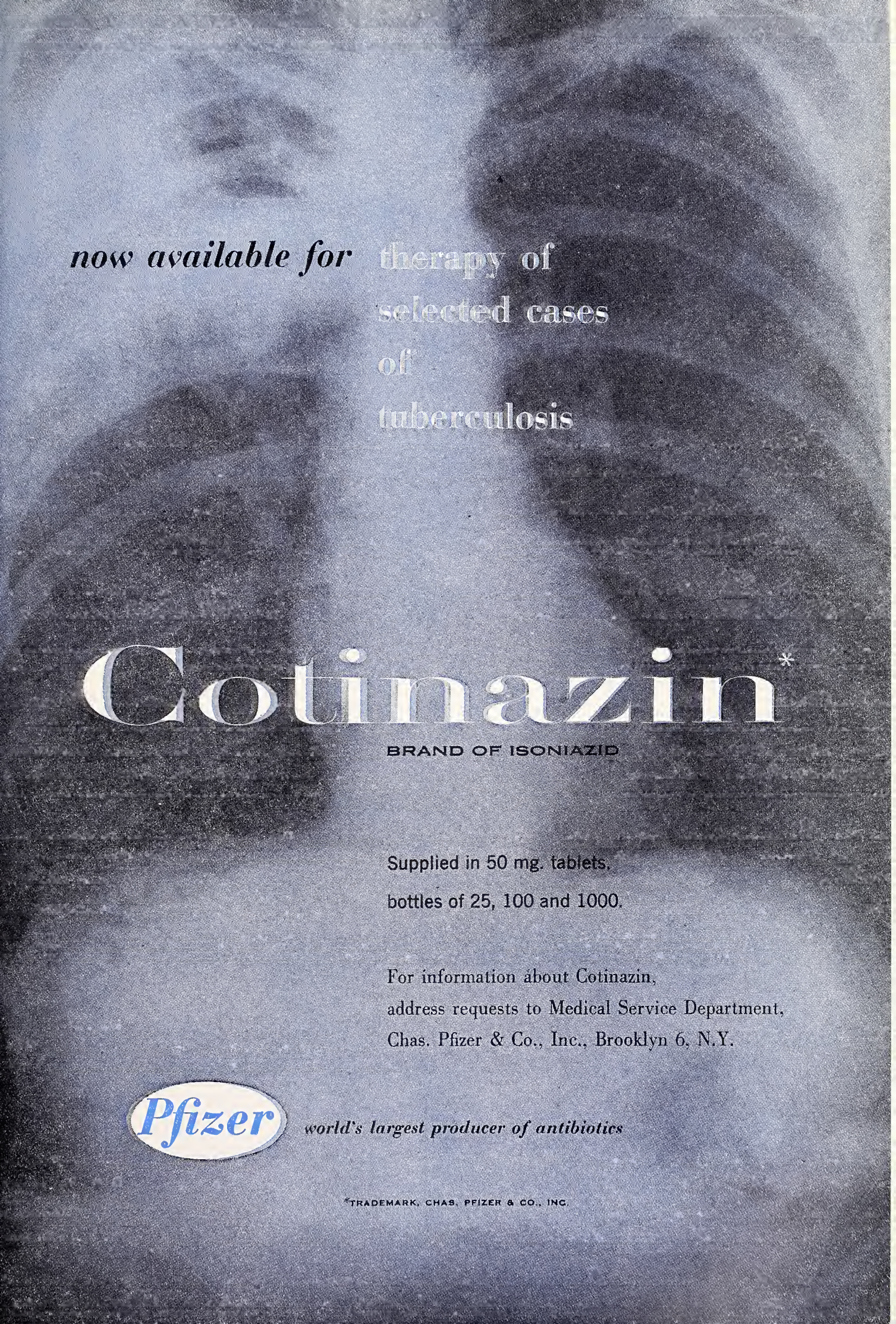
Harold McDonald, M.D., announces his association with Allan Ross, M.D., in medical practice at 188 Post Road, Darien.

Vincent Pepe, M.D., formerly of New Haven, will be associated with Hoyt Taylor, M.D., at 213 East Main Street, Meriden for the practice of obstetrics and gynecology. In addition to their Meriden office, Drs. Taylor and Pepe will maintain offices at 261 Center Street, Wallingford.

Clair Rankin, M.D., has announced his separation from the Connecticut Regional Blood Program and the removal of his office to 664 Farmington Avenue, Hartford, in order to devote full time to the practice of internal medicine and hematology.

Olindo O. Santopietro, M.D., announces the opening of an office at 48 Holmes Avenue, Waterbury for the practice of internal medicine.

Chester A. Wiese, Jr., M.D., announces the opening of his office for the practice of general surgery at 576 Farmington Avenue, Hartford.


now available for therapy of selected cases of tuberculosis
Cotinazin*
BRAND OF ISONIAZID
Supplied in 50 mg. tablets,
bottles of 25, 100 and 1000.
For information about Cotinazin,
address requests to Medical Service Department,
Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.
Pfizer
world's largest producer of antibiotics
*TRADEMARK, CHAS. PFIZER & CO., INC.

LETTERS TO THE EDITOR

Veterans Administration

Regional Office
95 Pearl Street
Hartford 12, Connecticut

June 20, 1952

To the Editor:

As you know, on June 4, 1952, the Food and Drug Administration released isonicotinic acid hydrazide for public sale in the treatment of tuberculosis.

Isonicotinic Acid Hydrazide is being employed at the Veterans Administration, Army, Navy Study Units, in the treatment of patients with any type of tuberculosis who may be considered to be "treatment failures," after adequate trial of standard sanatorium and antimicrobial measures. Changes in mood, mild delirium, hyper-reflexion, spontaneous muscular twitching (with normal electrolyte pattern), constipation, vasomotor instability, delay in micturition, have all been reported with varying frequency. Caution has been urged in the concomitant use of adrenergic drugs, antihistiminic agents, and derivatives of the belladona group.

At the present time we lack precise knowledge concerning optimal dosage, duration of therapy, chronic toxicity, and danger of emergence of hydrazide resistant bacilli before hospitalization is accomplished.

It appears that epilepsy and renal insufficiency are strong contra-indication of the use of this drug.

Because of these facts, it is the decision of our Central Office and consultants that Isonicotinic Acid Hydrazide shall not be used on an outpatient basis unless treatment has been initiated in a hospital, and its continuation on an outpatient basis is recommended by the hospital.

Your cooperation in disseminating this information to physicians through the CONNECTICUT STATE MEDICAL JOURNAL will be appreciated.

With best personal regards, I remain

Sincerely yours,

S. A. Schuyler, M.D.,
Chief Medical Officer

OUR NEIGHBORS

Maine

The Maine Medical Association enjoyed one of the largest attended sessions in its history when it met at Rockland in June for its 99th annual session. Meeting at the same time and place was the young and energetic Auxiliary, now three years old. Louis H. Bauer, president of the AMA addressed the general session and the Auxiliary. Connecticut was represented by the editor of the JOURNAL. The new editor of the *Journal of the Maine Medical Association* is Thomas A. Foster of Portland.

PHYSICIAN WANTED AT NORTH HAVEN

The Selectmen of the town of North Haven, Maine feel that they have an interesting offer to make a physician, who would enjoy living in a resort town on the coast of Maine, and serving the people of the town as general practitioner.

New Hampshire

New Hampshire now has one of the nation's outstanding modern functional hospitals complete to the nth degree in staff, equipment, conveniences, construction and maintenance. It is the Mary Hitchcock Memorial Hospital at Hanover, planned and designed to serve the Medical needs of the New Hampshire and Vermont residents in the upper Connecticut river valley.

"Medical Night" was observed May 14 with 125 doctors from the Twin States taking advantage of the open house program, sponsored by the hospital trustees and professional staff, to visit the new Faulkner House, latest $2,000,000 unit of a three year building program costing $3,200,000.

The new Faulkner House has many features some of which are the provision of a new department of Physical Medicine, central supply, piped oxygen and suction to each bed, and a postanesthesia ward in immediate connection with the operating rooms. The additional bed capacity of 120 provided by the Faulkner House brings the total hospital bed-capacity now to 325. The clinical staff has developed from five to forty men over the past 25 years and is now completely housed in its facilities within the institution. A much needed and fitting provision for



Salt is what makes things taste bad when it isn't in them.*

Most people find foods unappealing and insipid without salt. Therefore, when salt restriction is indicated, the patient must be impressed with the importance of a salt-free diet and must adhere faithfully to a rigid regimen. "With the development of such preparations as Neocurtasal . . . the problem of palatability and a salty taste has been fairly well solved . . ."[1]

Neocurtasal®

". . . trustworthy nonsodium-containing salt substitute"[2]

—lends the desired salty flavor to foodstuffs, and can be used in all salt-free and low sodium diets.

CONSTITUENTS: Potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch.

and

NEOCURTASAL
Iodized
(contains potassium iodide 0.01%)

Neocurtasal, trademark reg. U. S. & Canada.

Neocurtasal looks and pours like table salt and may be used in the same manner.

Both available in 2 oz. shakers and 8 oz. bottles.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

1. Merryman, M. P.: The Use of the Low Sodium Diet. *South Dakota Jour. Med. & Pharm.*, 2:57, Feb., 1949.
2. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

*Author unidentified. From Mencken, H. L.: A New Dictionary of Quotations. New York, Alfred A. Knopf, 1942, p. 1057.

a residence for interns and residents has been brought about by the allocation of the old Clinic building.

The Mary Hitchcock Memorial Hospital is a regional installation with upwards of 90 per cent of its admissions referrals from physicians outside the immediate Hanover area and located in communities in New Hampshire and Vermont. While it more directly serves the upper Connecticut river valley a surprisingly large number of people from the rest of New Hampshire utilize the expanding services of this now ultramodern hospital.

The growth of the hospital from a 36 bed institution in 1893 to its present position, hub of a regional medical center, has been nothing short of spectacular. Yet its value—brought about largely through the employment of a competent staff and a record of service—is reflected in the fact that more than 4,000 individuals, groups and corporations have contributed toward its medical and physical expansion, testifying to its attained position of high medical importance.

New York

Dr. George W. Kosmak has resigned as editor of the *New York State Journal of Medicine*. Dr. Kosmak's services to his State Medical Society cover the past 25 years, during 18 of which he was actively associated with the *Journal* in one capacity or another. The new editor is Dr. Laurance D. Redway, Harvard Medical School 1916, formerly an associate editor.

NEWS
from County Associations

Fairfield

William B. Terhune of Silver Hill, New Canaan was the guest speaker at the 99th annual session of the Maine Medical Association held in Rockland in June. Dr. Terhune spoke on "Making the Most of Man."

John R. Lyddy of Bridgeport began a three year residency in Obstetrics and Gynecology at the Boston City Hospital in Boston on July 1. Dr. Lyddy has practiced general medicine in Bridgeport and was assistant attending physician at Bridgeport since completing his internship at Bridgeport Hospital.

Recovering after recent illnesses at Bridgeport Hospital are Benjamin Horn and William Geer.

The new poliomyelitis ward at Bridgeport Hospital received its first patient on July 1. Polio patients will be taken care of in the general hospital in the future as recommended by the Medical Advisory Committee of the Fairfield County Medical Association.

A testimonial dinner for Henry S. Miles, ophthalmologist for sixty years in Bridgeport was held on July 22 at the University Club in Bridgeport. Dr. Miles has retired from active practice. He is one of the grand men of medicine.

Many of the county physicians are enjoying their annual summer vacations. The Fairfield County Medical Golf Association enjoyed their first competitive tournament at the Mill River Country Club in Stratford on June 25.

James R. Dickenson has been named fulltime director of the Norwalk Hospital Psychiatric Clinic, serving Westport and located in Norwalk. Dr. Dickenson for the past year has been chief of the Bridgeport Veterans Administration Clinic.

J. Leonard Vickers, a practising physician in Greenwich from 1933 to 1949 and since then medical director for Workmen's Compensation in West Virginia, was found shot to death in his room in Greenwich on June 21.

Hartford

John C. White of New Britain has been elected president of the Connecticut Heart Association to succeed William H. Resnick of Stamford.

Lane Giddings of Great Barrington, Massachusetts, has been appointed pathologist and director of the pathological laboratory at Manchester Memorial Hospital.

Middlesex

Herbert Levine has opened his office at 121 Main Street, Middletown. He is limiting his practise to internal medicine.

New Haven

William C. McGuire, chief of the pediatric service at St. Raphael's Hospital, died at his home on June 15 at the age of 65 years. Dr. McGuire was a past president of the staff at St. Raphael's and chairman of its education department. He was also past president of New Haven County Medical Association.

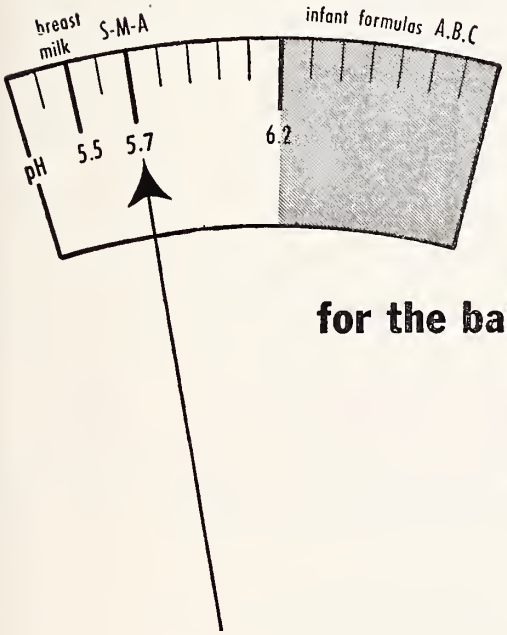
Frank P. Heery, for the past 45 years a surgeon for the New Haven Police Department, died at the New Haven Hospital June 29 after a long illnes. He was 80 years old.

clinical tests prove S-M-A®

is the only infant feeding formula that



- establishes a predominantly gram-positive flora—similar to the flora of the lower intestine of the breast-fed baby.[1]



- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

for the baby S-M-A means:

1 *Better absorption of minerals, especially calcium.*

2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

3 *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.

4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin* B_{12}. Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. *40*:152 (Feb.) 1952.
2. Watson, J.: Gordon Research Conf. Vitamins and Metabolism, 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

Wyeth®

Dr. Barnes Sanitarium

STAMFORD, CONNECTICUT

An ideally located and excellently equipped Sanitarium, recognized by members of the medical profession for forty-two years for merit in the treatment of NERVOUS AND MENTAL DISORDERS, ALCOHOLISM AND CONVALESCENTS. Equipment includes an efficiently supervised occupational therapy department, also facilities for Shock Therapy.

Reasonable rates — full particulars on request

F. H. BARNES, M.D.

Stamford 2-1621 Est. 1898

Founded 1879

RING SANATORIUM

For the study, care and treatment of emotional, mental, personality and habit disorders.

All recognized psychiatric therapies are used as indicated.

Cottage accommodations meet varied individual needs. Limited facilities for the continued care of progressive disorders requiring medical, psychiatric or neurological supervision.

Benjamin Simon, M.D.
Director

Charles E. White, M.D.
Louis Brenner, M.D.
William R. Shelton, M.D.
Associates

Consultants in All Specialties

Francis W. Russell
Executive Secretary

Arlington Heights
Massachusetts

Telephone
AR 5-0081

NEW BOOKS IN REVIEW

BACITRACIN. A Review and Digest of the Literature Up To and Including January, 1952. *New York: Research Division, S. B. Penick & Company.* 1952. 127 pp.

Reviewed by Wilson F. Smith

According to the foreword of this little book of 127 pages, its purpose is "to make available for use by the pharmaceutical industry a review of the data which have accumulated on the clinical usefulness of bacitracin and to direct attention to the wide potential of this drug based upon its known synergistic action with other antibiotics."

In the introduction is given a list of the properties of an ideal antibiotic, and then throughout the rest of the text the properties of bacitracin are discussed and the conclusion is reached that "within its antibacterial spectrum, bacitracin approaches the ideal more nearly than any other antibotic." The first five chapters cover the historical facts, the chemistry, the standardization, the pharmacology and the bacteriological aspects of bacitracin. There then follow chapters on the clinical results with bacitracin, the place of bacitracin in veterinary medicine, the synergistic action of bacitracin and its dosage and formulations. The last chapter is a summary and gives a resume of the properties of bacitracin that are considered as making it approach the ideal antibiotic. One hundred ninety-eight bibliographical references conclude the book. There is no index, though the table of contents is detailed.

Undoubtedly this book fulfills its stated purpose. It also discusses the status of bacitracin in the armamentarium of the general practitioner as well as the specialist. Whether it is more optimistic than is warranted, time alone will tell.

FUNDAMENTALS OF PSYCHIATRY. (Fifth Edition.) *By Edward A. Strecker,* M.D. Lippincott. 250 pp. with Glossary. $4.50.

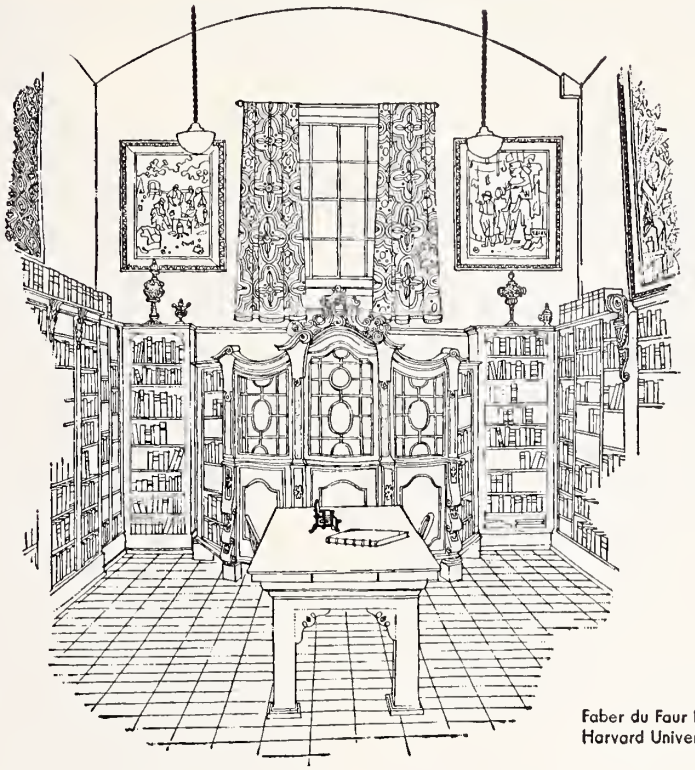
Reviewed by Francis J. Braceland

The popularity of this volume which first appeared in the war years is attested to by the fact that it has run through five editions. It is a simple, clear and direct exposition of fundamental psychiatric knowledge presented in orthodox fashion. Its value to the geenral practitioner is enhanced by the inclusion of a glossary of psychiatric terms, usually the bête noir of the nonpsychiatrist.

Written in a manner understandable to the physician, it begins with a discussion of historical factors and a consideration of predisposing and exciting causes of the psychoses. The etiology is then considered and the psychoses described under the headings of organic, toxic and functional psychoses for the sake of brevity and clarity. The recent appearance of a new classification issued under the auspices of the American Psychiatric Association will not nullify the authority of the older classification used in this volume.

Chapters on treatment including Psychotherapy, Psychosomatic Medicine, Psychiatry and the War, and the Nurse and the Psychiatric Patient add to the general usefulness of the book. It should find general favor with practioners

New aureomycin minimal dosage for adults —four 250 mg. capsules daily, with milk.



Faber du Faur Library, Harvard University

From among all antibiotics, Urologists often choose

AUREOMYCIN

Hydrochloride Crystalline

because Aureomycin concentration is much higher in the urine than in the blood, so that very satisfactory therapeutic urinary levels may be reached with moderate oral dosage.

Aureomycin appears in high concentration in the urine, and can be detected for as long as 55 hours after a single oral dose of 0.5 to 0.7 Gm.

Aureomycin serum levels are maintained for as long as 12 hours after oral administration, oral doses of 5 to 10 mg. per kilo at 6-hour intervals being adequate for this purpose.

Aureomycin has its activity greatly increased in an acid medium, rendering it highly useful in the normally acid urine.

Aureomycin has been reported to be useful in infections commonly seen by urologists, including:
Genitourinary infections caused by *E. coli*, *A. aerogenes*, *S. faecalis*, paracolon bacillus, staphylococcus, streptococcus, and enterococcus • Chronic or Resistant Urinary Infection* • Gonorrhea • Nonspecific Urethritis*

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

*When caused by aureomycin-susceptible organisms.

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY 30 Rockefeller Plaza, New York 20, N.Y.

AVOID "OVERTREATMENT DERMATITIS"

"Overtreatment dermatitis is today a prevalent and often disabling cutaneous disturbance."*

* Lane, C. G., "Therapeutic Dermatitis", New Eng. J. Med., 246:77-81, 1952

AVEENO...the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.

Send for samples E. FOUGERA & CO., INC. • Distributors • 75 Varick St., New York 13, N. Y.



CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years,* are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

Approved interneships (rotating), and residencies in medicine and obstetrics-gynecology; surgical residencies approved for training in preparation of surgical specialties; 215 bed general hospital, modern, well equipped; house staff allowed full range under proper medical supervision with wide diversification of diseases; excellent training, practical, in active surgical service and obstetrics-gynecology; full-time radiologist, pathologist and anesthesiologist; active interne and resident training program; this coastal city with an array of beautiful beaches is the mecca for vacationers in the East; recreational facilities, especially marine, unlimited. Full maintenance, uniforms, assistance in obtaining apartment if married; stipend—internes $2,400, assistant residents $3,000, residents $3,600. Class A medical school graduates only. The Lawrence and Memorial Associated Hospitals, New London, Connecticut, Joseph M. Wool, M.D., Chairman, Committee on Residents and Internes.

interested in understanding basic principles of the discipline of psychiatry without delving too deeply into psychodynamics.

The writer is one of the "elder statesmen" of American Psychiatry and this work is clear, concise, and well written. It should appeal also to teachers and clergymen interested in understanding common psychiatric syndromes which they are called upon to recognize in their professional pursuits.

THE PRINCIPLES OF REFRACTION. By Sylvester Judd Beach, A.B., M.D., F.A.C.S. With an introduction by *Walter B. Lancaster,* M.D. *St. Louis: C. V. Mosby.* 1952. 155 pp.

Reviewed by LEON W. ZIMMERMAN

This little book contains only one hundred and fifty-five easy to read pages, but it is an epitome of fundamentals in the art of refraction. As Dr. Beach points out in his foreword, the word refraction means a physical alteration in direction of a ray of light, but by usage has also come to have a more general implication which includes those procedures used in the proper fitting of eye glasses.

The material appears to be a collection of personal notes the author has used in teaching, to which he has given much time in recent years, and contains many homely illustrations characteristic of one who has had a fruitful life in ophthalmology, has seen it grow as a science and participated actively in its development while at the same time carrying on a busy practice which had its beginning at a time when cataract extractions often, of necessity, were done in the home on the family table. Yet it is not filled with anecdotes but rather summarizes techniques which are now accepted as common practice in every day office work so that their basic principles often are but dimly remembered by the busy physician. He describes in simple terms the optical laws upon which refraction is founded, without recourse to mathematics and scientific elucidation. Then he briefly discusses refractive errors, comparing the process of fitting a proper lens for a particular eye to neutralization of lenses in a trial case. Included is a discussion of the Conoid of Sturm which is illustrated with some of the typical drawings which accentuate the simplicity the author manages well to keep in his treatment of this subject.

After a mention of desirable records and forms, the discussion procedes through retinoscopy, which Dr. Beach



COSMETIC *HAY FEVER?*

Prescribe UNSCENTED AR-EX Cosmetics

When perfumes or scented cosmetics cause allergic reactions — prescribe UNSCENTED AR-EX COSMETICS. Clinically tested to meet your high standards. Smart, fashion-right for patient acceptance. All needed beauty aids. *Send for free Formulary*

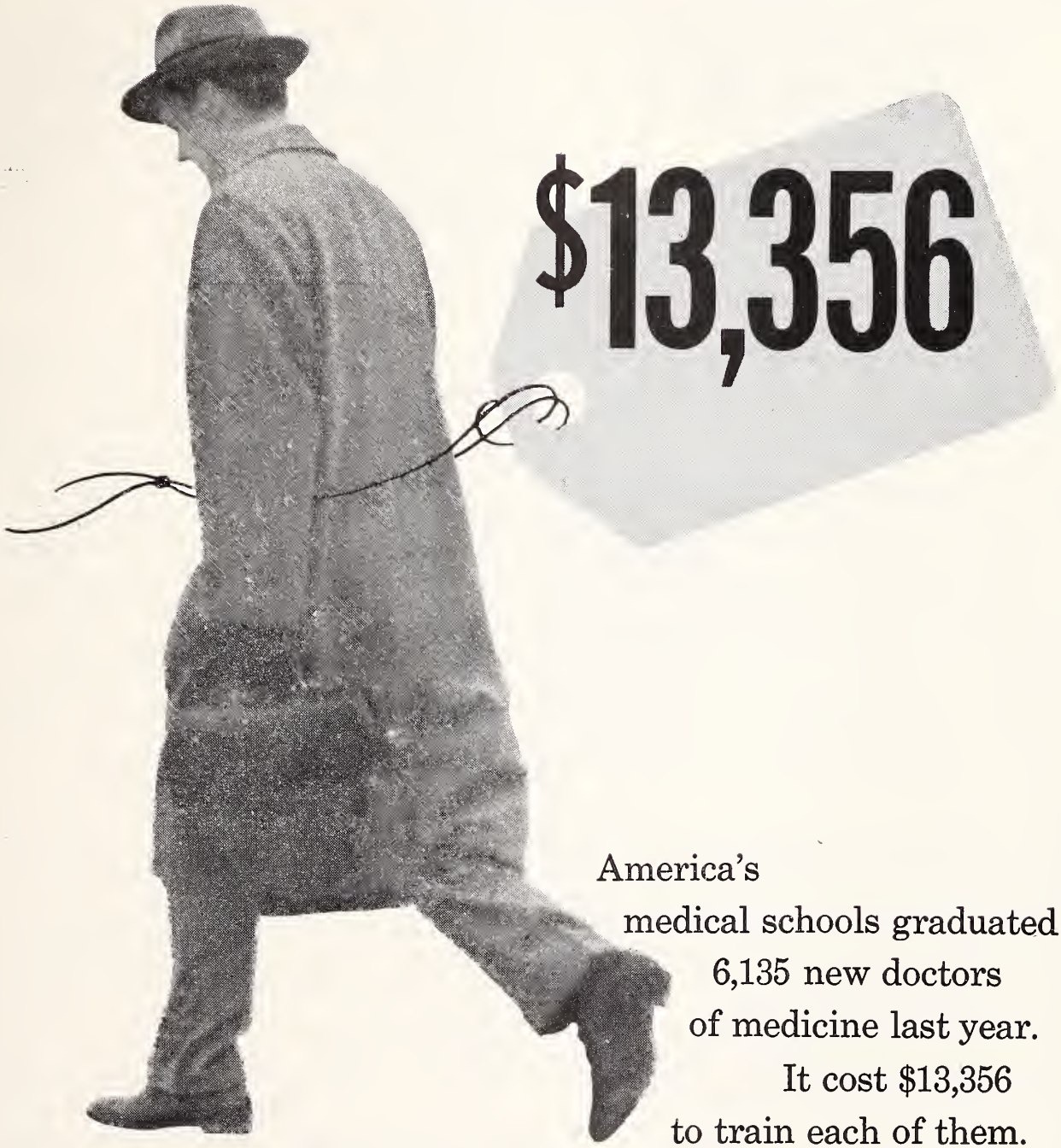
UNSCENTED

AR-EX COSMETICS, INC., 1036 W. VAN BUREN ST., CHICAGO 7, ILL.



AR-EX
HYPO-ALLERGENIC
Cosmetics

Clinically tested on allergic patients for use by allergic patients



America's
medical schools graduated
6,135 new doctors
of medicine last year.
It cost $13,356
to train each of them.
Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.

American Medical Education Foundation

535 North Dearborn Street, Chicago 10

CROTON MANOR SANITARIUM
ALBANY POST ROAD, ROUTE 9
CROTON-ON-HUDSON, N. Y.
Tel. Croton 1-4731
A private sanitarium for individual care and treatment of nervous and mental disorders; senile and habit cases. Beautifully furnished. Overlooking Hudson River. Every room with bath. All accepted therapies administered. Brochure on request. Licensed by New York State Department of Mental Hygiene and approved by the American Medical Association
Filomena Doherty, R.N., *Director*
George L. Lake, M.D., D.P.N., *Physician-in-Charge*
35 miles from New York City

considers a sine qua non, to a routine of subjective refraction, which the writer has evidently found eminently successful. Obviously one is not expected to use all the methods in a given case, but a thorough understanding of each enables the refractionist to choose the most desirable and effective procedure for a particular individual and at the same time have several techniques which are alternatives and can serve as cross checks to one another if necessary. The Manifest Method is mentioned only to be condemned as a primary means of arriving at a final prescription. An endeavor is made to state the advantages and limitations of each procedure, such as the tests for astigmatism, in elementary terms and to describe the technique in an equally simple manner. In this the author succeeds admirably.

As one might expect from the title of the book, this chapter is the heart of it, comprising about one third. Fogging is discussed in considerable detail and it is evident the author believes it to be one of the best methods of determining accurately an error of refraction. The use of the cross cylinder in determining both axis and power is fully explained. Problems inherent in present acuity charts are mentioned and suggestions made for improvements. Cyclodemia is also a method the author evidently feels has enjoyed too little popularity among the lesser known techniques for he gives it as much space as to the comments on cross cylinder, the use of which is more universal.

A chapter on the cyloplegic refraction is written in the same interesting and practical style, with advantages and disadvantages discussed matter of factly as they would be found in daily practice. Then follows a short chapter on treatment of ametropia in which the author gives some useful hints to be followed in deciding on the final glass for the patient, once the examination is completed. The last discussion is one concerning the ocular neuroses, another aspect of the whole problem which Dr. Beach rightly feels too many prescribers of glasses fail to adequately evaluate.

There is some repetition in this little book, but on the whole it is well edited and contains a great deal of practical information written in an enjoyable manner. While it is not easily readable at one sitting, it can readily be covered in two or three short periods, and its substance is pertinent to every day practice. The novice will find it a concise refresher course and the senior men will enjoy comparing their experiences with those of the author in this short discourse on the principles of refraction. Perhaps some recognizing its value and scope will be stimulated to a similar endeavor and will add their gleanings from the years to the growing store of knowledge of ophthalmology.

Polio Funds

A total of $2,395,039 in March of Dimes funds—one of the largest aggregate awards ever made by the National Foundation for Infantile Paralysis—has just been allocated for polio research and professional education to 26 medical schools, hospitals, research institutions and educational organizations in this country and one in Canada. This brought to more than $38,000,000 the amount provided by the March of Dimes organization for research, education and medical care grants since 1938.

Of the total just authorized, $1,455,692 was allocated for research seeking prevention of the disease and improved methods of treatment, and $939,347 for programs in professional education.

For investigations dealing with virus research, among the grants made was one to Yale University, of $103,242, under the direction of Dr. John R. Paul, professor of preventive medicine.

In addition, $422,305 was appropriated to expand the professional scholarship and fellowship programs in the fields of medicine and related biological and physical sciences, public health for physicians, physical therapy and medical social work. These awards are administered at National Foundation headquarters and are made upon the recommendation of fellowship and scholarship committees.

The announcement of the March of Dimes grants also disclosed that the National Foundation will continue its practice of paying its share of the indirect costs of research. The Board of Trustees has approved approximately $300,000 for paying "a justifiable portion of the indirect costs of research which are not reflected in the budget of a research project." These costs include heat, power and light, building maintenance, and other similar operating and administrative charges which are not directly related to the research but which nevertheless drain funds from the university.

Table of Contents : September 1952

Diarrhea in Infancy — Stuart Shelton Stevenson, M.D., Pittsburgh, Pennsylvania — 671

The Early Recognition of Endometriosis and Hormonal Treatment With Testosterone — John M. Freiheit, M.D., F.A.C.S., Waterbury — 674

The Control of Convulsive Seizures by Endocrine Therapy — Maurice R. Moore, M.D., F.A.C.P., Norwich — 679

The Effect of Premedication of Cortisone On the Healing of Wounds In An Infant — Albert Rubin, M.D., and Moses D. Lischner, M.D., Hartford — 682

Standing Orders—The Responsibility of the Industrial Physician — Jan Lieben, M.D., Hartford — 683

The Doctor's Own Mental Health — Everett S. Rademacher, M.D., New Haven — 685

EDITORIALS

Post Doctorate Education 691
Surgical and Medical Expense Protection—Some Figures 691
Citizens and Doctors 692
Dr. William T. Salter 692
Our Clinical Congress 693

DEPARTMENTS

The President's Page 696
The Secretary's Office 697
The Historian's Note Book
Joseph Addison On the Prevention of Disease
George Blumer, M.D., San Marino California 699
Letters to the Editor 700
Public Relations 702
News From Washington 706
Military Affairs 709
From Our Exchanges 712
Woman's Auxiliary 714
News From County Associations 718
News From Yale University School of Medicine 722
New Books in Review 722

MISCELLANEOUS

Advance Program—27th Clinical Congress 665
The Doctor's Office 703
Programs of Semi-Annual County Association Meetings 690
Special Notices 717

1967 Participating Physicians Can't be Wrong

. . . and that's one reason why CMS is the choice of 580,000 Connecticut people.

Since the CMS in-hospital care program went into effect on June 1, the Doctors Plan has added 142 Participating Physicians. The total now stands at 1,967 . . . and chances are there'll be over 2,000 by fall.

The support of Participating Physicians is the key to CMS success. As their number continues to grow, with the addition of physicians engaged in non-surgical practices, the Doctors Plan can look forward to even greater success in the future.

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI SEPTEMBER, 1952 NO. 9

TWENTY-SEVENTH CONNECTICUT CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

NEW HAVEN HOSPITAL AND THE YALE SCHOOL OF MEDICINE, Cedar Street, New Haven

September 17, 18, 1952

PROGRAM

WEDNESDAY, SEPTEMBER 17

MORNING SESSIONS

9:30 REGISTRATION

10:00 DIABETIC COMA—PHYSIOLOGY AND TREATMENT — Brady Auditorium

Garfield G. Duncan, *Philadelphia; Clinical Professor of Medicine, Jefferson Medical College; Director Medical Division of Pennsylvania Hospital*

Presiding: Hugh L. Dwyer, *New Haven*

Discussants: Paul H. Lavietes, *New Haven*
Wilson F. Smith, *Hartford*

ISONIAZID IN THE TREATMENT OF TUBERCULOSIS — Gymnasium—Medical School

Ralph Tompsett, *New York; Associate Professor of Clinical Medicine, Cornell University Medical School; Associate Attending Physician, New York Hospital*

Presiding: Kirby S. Howlett, Jr., *Shelton*

Discussants: John B. O'Connor, *Shelton*
George C. Wilson, *Norwich*

CAUSES OF SUDDEN DEATH — Farnam Amphitheater

Milton Helpern, *New York; AssociateProfessor of Forensic Medicine, New York University Postgraduate Medical School; Depnty Chief Medical Examiner, New York City*

Presiding: Walter Weissenborn, *Hartford*

Discussants: Ettore F. Carniglia, *Hartford*
Brae Rafferty, *Willimantic*

WEDNESDAY, SEPTEMBER 17

11:00 GOUT — Brady Auditorium

John H. Talbott, *Buffalo; Professor of Medicine, University of Buffalo School of Medicine, Physician-in-Chief, Buffalo General Hospital*

Presiding: Hugh L. Dwyer, *New Haven*

Discussants: Joseph F. Jenovese, *Hartford*
Paul H. Lavietes, *New Haven*
Edward Nichols, *Hartford*

MEDICAL MANAGEMENT OF HYPERTHYROIDISM — Farnam Amphitheater

Earle M. Chapman, *Boston; Associate in Medicine, Harvard Medical School; Associate Physician, Massachusetts General Hospital*

Presiding: Orpheus J. Bizzozero, *Waterbury*

Discussants: Edward H. Kirschbaum, *Waterbury*
George B. McAdams, *Hartford*

CRITIQUE OF CURRENT THEORIES ON THE PATHOGENESIS OF ARTERIOSCLEROSIS — Gymnasium—Medical School

Frederick T. Hatch, *New York; Instructor in Medicine, College of Physicians and Surgeons, Columbia University; Research Fellow, Columbia University Research Service, Goldwater Memorial Hospital, New York*

Presiding: Chester W. Fairlie, *West Hartford*

Discussants: John H. Heller, *New Haven*
Paul H. Twaddle, *Hartford*

12:30 LUNCHEON—New Haven Hospital, Fifth Floor

AFTERNOON SESSIONS

2:00 DIAGNOSIS AND TREATMENT OF ARTHRITIS — Brady Auditorium

Russell L. Cecil, *New York; Clinical Professor of Medicine (Emeritus), Cornell University Medical School; Consulting Physician, New York Hospital*

Presiding: Gideon K. DeForest, *New Haven*

Discussants: Joseph J. Lankin, *Hartford*
Marjorie B. Patterson, *Greenwich*

PRESENT DAY DRUG THERAPY IN HYPERTENSION — Gymnasium—Medical School

David Ayman, *Boston; Instructor in Medicine, Tufts Medical School, Chief of the Hypertension Clinic, Beth Israel Hospital, Boston*

Presiding: Arthur J. Geiger, *New Haven*

Discussants: John H. Heller, *New Haven*
Harry E. Klebanoff, *New Haven*

TOXEMIAS OF PREGNANCY — Farnam Amphitheater

Leon C. Chesley, PH.D., *Jersey City; Biochemist, Margaret Hague Maternity Hospital*

Presiding: Luther K. Musselman, *New Haven*

Discussants: Donald A. Bristoll, *New Britain*
Louis F. Middlebrook, *Hartford*

WEDNESDAY, SEPTEMBER 17

3:30 PEDIATRIC SEMINAR — Gymnasium—Medical School

David H. Clement, *New Haven, presiding*

ABDOMINAL PAIN IN INFANCY AND CHILDHOOD

Orvar Swenson, *Boston; Surgeon-in-Chief, Boston Floating Hospital for Infants and Children; Associate Professor in Surgery, Tufts College Medical School*

Discussants: Louie N. Claiborn, *New Haven*
Max Taffel, *New Haven*

HYPOPLASTIC AND APLASTIC ANEMIAS OF INFANCY AND CHILDHOOD

Carl H. Smith, *New York; Associate Clinical Professor of Pediatrics, Cornell University Medical School; Associate Attending Pediatrician, New York Hospital*

Discussants: Allan Erslev, *New Haven*
Robert P. Zanes, Jr., *New Haven*

KIDNEY DISEASE IN CHILDREN

Henry L. Barnett, *New York; Associate Professor, Department of Pediatrics, Cornell University Medical School; Associate Attending Pediatrician, New York Hospital*

Discussants: Robert E. Cooke, *New Haven*
Daniel C. Darrow, *New Haven*

PROGRESS REPORT ON ACTH AND CORTISONE — Brady Auditorium

Currier McEwen, *New York; Associate Professor and Dean, New York University College of Medicine; Visiting Physician, Bellevue Hospital*

Presiding: John C. Leonard, *Hartford*

Discussants: Stewart P. Seigle, *Hartford*
George A. Wulp, *Hartford*

CLINICAL APPLICATION OF RADIO-ACTIVE ISOTOPES IN MALIGNANCY — Farnam Amphitheater

Richard H. Chamberlain, *Philadelphia; Professor of Clinical Radiology, Graduate School of Medicine, University of Pennsylvania; Associate Professor of Radiology, School of Medicine, University of Pennsylvania*

Presiding: Arnold H. Janzen, *New Haven*

Discussants: John C. Larkin, *New Britain*
Ralph T. Ogden, *Hartford*

INDICATIONS FOR AND CONTRA INDICATIONS TO BLOOD TRANSFUSIONS — Fitkin Amphitheater

Lamar Soutter, *Boston; Director of the Blood Program at Massachusetts General Hospital*

Presiding: Ralph E. Kendall, *Hartford*

Discussants: Charles M. Barbour, Jr., *Hartford*
Charles H. Peckham, *Manchester*
John G. Snaveley, *Stamford*

7:00 P. M. RECEPTION AND DINNER FOR VERNON W. LIPPARD, Dean, Yale University School of Medicine; New Haven Country Club

Reservation cards for this dinner will be included with the program of the meeting which will be distributed to all members

THURSDAY, SEPTEMBER 18

MORNING SESSIONS

9:30 Registration

10:00 Reconstructive Surgery of the Hand — Brady Auditorium

J. William Littler, *New York; Assistant Attending in Surgery, Roosevelt Hospital, New York; Instructor in Surgery, College of Physicians and Surgeons, New York*

Presiding: Paul W. Vestal, *New Haven*

Discussant: Ned M. Shutkin, *New Haven*

The Management of Acute Head Injuries — Gymnasium—Medical School

A. Price Heusner, *Boston; Instructor in Neurology, Harvard Medical School; Associate Surgeon for Neurosurgery, Boston City Hospital*

Presiding: William J. German, *New Haven*

Discussants: Irving J. Sherman, *Bridgeport*
S. J. Silbermann, *Hartford*

A Re-examination of the Treatment of Severe Burns — Farnam Amphitheater

Francis D. Moore, *Boston; Moseley Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital*

Presiding: Gervase J. Connor, *New Haven*

Discussants: Philip S. Brezina, *Bristol*
Samuel C. Harvey, *New Haven*

11:00 Carcinoma of the Breast — Gymnasium—Medical School

Ernest M. Daland, *Boston; Chief of Staff, Pondville Cancer Hospital; Consulting Surgeon, Massachusetts General Hospital*

Presiding: N. William Wawro, *Hartford*

Discussants: Philip G. McLellan, *Hartford*
Douglas J. Roberts, *Hartford*

Heart Surgery — Brady Auditorium

Dwight E. Harken, *Boston; Assistant Clinical Professor of Surgery, Harvard Medical School; Thoracic Surgeon, Peter Bent Brigham Hospital*

Presiding: Bliss B. Clark, *New Britain*

Discussants: William W. L. Glenn, *New Haven*
R. Leonard Kemler, *Hartford*

Plastic Operations Upon Organs of the Genito-Urinary Tract — Farnam Amphitheater

Oswald S. Lowsley, *New York; Director of Oswald Swinney Lowsley Foundation; Urologist, St. Clare's Hospital, New York*

Presiding: Thomas M. Feeney, *Hartford*

Discussants: Charles E. Jacobson, Jr., *Hartford*
Chris H. Neuswanger, *Waterbury*

12:30 Luncheon—New Haven Hospital, Fifth Floor

THURSDAY, SEPTEMBER 18

AFTERNOON SESSIONS

2:00 SURGICAL TREATMENT OF MALIGNANT TUMORS OF THE LUNG — Brady Auditorium

William Francis Rienhoff, Jr., *Baltimore; Associate Professor of Surgery, The Johns Hopkins University; Surgeon, the Johns Hopkins Hospital*

Presiding: Gustaf E. Lindskog, *New Haven*

Discussants: Max G. Carter, *New Haven*
Alfred Hurwitz, *Newington*

PITFALLS IN THE TREATMENT OF FRACTURES — Gymnasium—Medical School

Charles S. Neer, *New York; Instructor, Orthopedic Surgery, College of Physicians and Surgeons, Columbia University; Assistant Attending Orthopedic Surgeon, New York Orthopedic Hospital-Columbia Presbyterian Medical Center, New York*

Presiding: Burr H. Curtis, *Hartford*

Discussants: Arthur S. Griswold, *Hartford*
Robert G. Reynolds, *Hartford*

MEDICAL MANAGEMENT OF PERIPHERAL VASCULAR DISEASE — Farnam Amphitheater

William T. Foley, *New York; Assistant Professor of Medicine, Chief of Vascular Clinic, New York Hospital-Cornell University Medical College*

SURGICAL MANAGEMENT OF PERIPHERAL VASCULAR DISEASE

Jere W. Lord, Jr., *New York; Associate Professor of Clinical Surgery, New York University Postgraduate Medical School; Attending Surgeon, University Hospital*

Presiding: Paul Kunkel, *Newington*

Discussants: William W. L. Glenn, *New Haven*
Gioacchino S. Parrella, *Milford*

3:30 DYNAMIC THERAPEUTICS IN CHRONIC DISEASE — Brady Auditorium

Henry H. Kessler, *Newark, N. J.; Medical Director, Kessler Insttiute for Rehabilitation*

Presiding: Thomas F. Hines, *New Haven*

Discussants: John C. Allen, *Hartford*
Nila K. Covalt, *Rocky Hill*

THE CONTRIBUTIONS OF ENDOCRINOLOGY TO OFFICE GYNECOLOGY — Gymnasium—Medical School

Somers H. Sturgis, *Boston; Assistant Clinical Professor of Gynecology, Harvard Medical School; Senior Associate in Gynecological Surgery, Peter Bent Brigham Hospital*

Presiding: Joseph H. Howard, *Bridgeport*

Discussants: Hugh K. Miller, *Stamford*
W. Leslie Smith, *Hartford*

SURGERY OF THE GASTRO-INTESTINAL AND BILIARY TRACTS — Farnam Amphitheater

Richard B. Cattell, *Boston; Surgeon, The Lahey Clinic, New England Baptist Hospital and New England Deaconess Hospital*

Presiding: Thacher W. Worthen, *Hartford*

Discussants: John D. Booth, *Danbury*
Philip G. McLellan, *Hartford*

THURSDAY, SEPTEMBER 18

GENERAL INFORMATION

REGISTRATION FEE

The registration for members of the Connecticut State Medical Society is $3.00. The fee for persons who are not members of the Society is $4.00. Payment of the registration fee provides for admission to all sessions of the Congress.

Hospital residents, interns, and medical students will be admitted to all sessions without charge, if a statement of their position, signed by an official of the hospital or medical school, is presented at the registration desk.

MEETING PLACE

All of the sessions will be held in the Gymnasium, Brady Auditorium, Farnam and Fitkin Amphitheaters, at the School of Medicine and New Haven Hospital.

TELEPHONE

All telephone messages will be received at New Haven—LO 2-1161.

LUNCHEONS

Cafeteria luncheons will be served at the New Haven Hospital, fifth floor, on the two days of the Congress.

PARKING

There are two public parking areas near the hospital. There is metered curb parking. Automobile stickers will be provided for all registrants.

292,500,000,000,000,000

The above astronomical figure is the number of red cells provided through the Connecticut Regional Blood Program to the hospitals of this State for the treatment of patients requiring transfusion. The availability of blood through this program has led consistently to its increased usage during the past two years and has required the combined efforts of the Red Cross Program, the hospitals and their blood banking committees to be successful.

The profession has a special duty in explaining to its patients that there is no substitute for blood, that blood is continuously needed and that blood can only be procured from one source, the general population. It is only by the cooperation of the medical profession in stimulating its recruitment that blood can be made freely available to all.

The Blood Program is a medically directed program and its future success will depend upon the support given to the Program by the individual physician in his contacts both with patients and with friends.

DIARRHEA IN INFANCY

STUART SHELTON STEVENSON, M.D., *Pittsburgh, Pennsylvania*

The Author. *Research Professor of Pediatrics, University of Pittsburgh School of Medicine*

DIARRHEA persists as an important cause of infant mortality in infancy. In 1949 it killed 6,809 American babies; it accounted for 1.4 per cent of deaths under one month of age and 16.1 per cent of deaths from one to twelve months of age (data from Children's Bureau). Uncounted numbers of babies, furthermore, die officially each year from some other disease where in reality their deaths are the direct result of the diarrhea which complicated the primary illness. Diarrhea is an infant's way of reacting to infection. It is a potential and powerful threat to every infant's life throughout his first two years. In addition, it is responsible each year for countless thousands of ill babies whose growth and development are retarded because of the resulting malnutrition and prolonged convalescence.

These facts are disgraceful to record in a country which takes pride in its sanitation and its standards of infant care. It is not unfair to state that many of these afflicted babies should never have had diarrhea in the first place and in any event, with proper treatment, they should not have died because of it.

PREVENTION

Diarrhea in infancy is usually the result of enteric or parenteral infection. Factors which predispose to infection—warm, humid months which favor quick bacterial growth in food and water, malnutrition and prematurity which lower resistance to infection—predispose to diarrhea. Only rarely is serious diarrhea the result of allergy or other disease. Thus, the prevention of diarrhea means in large part the protection of the infant from infection.

TREATMENT

An infant dies from diarrhea because he loses salts and water. He has only small reserves of these and their depletion causes renal failure, acidosis and shock. Obviously, laxatives and enemas, which increase these losses, are absolutely contraindicated in the treatment regime. It is possible to formulate a simple and practical treatment plan which does not require elaborate chemical determinations, does not usually necessitate intravenous techniques and utilizes only commercially available solutions. This plan aims at replacing the salt and water losses which are known to exist in most infants who have diarrhea. Chemical data concerning serum concentrations of electrolytes are always desirable when they are quickly and accurately obtainable: an occasional baby for instance may suffer from an excessive loss of water with minimal sodium depletion and the regime outlined here will not be adequate. Thus, if an infant does not improve after two days of treatment it will probably be wise to obtain blood chemistries and special consultation.

ESTIMATING THE SEVERITY OF THE DIARRHEA

To treat diarrhea, it is necessary first to estimate its severity. Ask about the stools: how loose are they? How frequent? Quantity? For how many days has the diarrhea persisted? Liquid stools may soak into the diaper and be mistaken for urine; make certain that the mother has not been misled by this state of affairs. Mucus and small amounts of blood are often present because of intestinal irritation and do not necessarily imply bacillary dysentery. A green color shows merely that passage through the intestine has been rapid and unchanged bile is being excreted.

Is the baby vomiting or does he have a fever? These will cause further water and salt loss and increase the seriousness of his condition. How long since he has urinated? Anuria signals the presence of severe dehydration and possibly shock. If his mother knows how much he weighed prior to his illness, weigh him and calculate his weight loss. This is a most helpful measure of the severity of his diarrhea.

From the Children's Hospital of Pittsburgh and The Department of Pediatrics of the University of Pittsburgh School of Medicine

Presented at the 160th Annual Meeting, Connecticut State Medical Society, Hartford, April 30, 1952

Examine the baby: doughy skin, a sunken fontanel and a scaphoid abdomen suggest severe dehydration. Drowsiness, cold extremities, slate-grey skin, flaccidity and a rapid thready pulse mean that he is in shock.

Attempt to classify the diarrhea as mild, moderate or severe but take care not to under estimate its seriousness. In particular, worry about an infant whose diarrhea has persisted for several days even though he does not seem to be gettting worse; for a time he can draw on reserves of water in his intercellular spaces and maintain his circulating blood volume. When this reservoir is exhausted, however, his blood volume will drop suddenly and he will go quickly into shock which may possibly be irreversible.

TREATMENT OF MILD DIARRHEA

If the diarrhea is mild—of brief duration, perhaps eight or ten moderately loose stools in a day's time with minimal signs of dehydration and no signs of shock—it is feasible to treat it at home. Begin treatment immediately and do not wait to learn the etiology. If the child has obvious signs of infection take appropriate cultures and prescribe adequate chemotherapy.

Stop all milk and solid food by mouth for 24 hours. Feed the infant as much as he will take of this mixture:

1 quart boiled water
1 teaspoon salt (0.5 N)
3 tablespoons sugar (4.5 per cent)

Add 2 mgm. of thiamin and 100 mgm. of ascorbic acid to the mixture, to replace his losses of these water soluble vitamins. Continue this regime during the second 24 hours if he is not better. If the diarrhea ceases, begin very cautiously to feed one-half-skimmed milk, adding one and one half tablespoons of sugar to each cup of milk. Give only very small amounts for a day or so until it is certain that the diarrhea will not recur.

During these days, feed enough additional boiled water or the above salt-sugar solution to allow the infant a daily fluid intake of two and one half ounces per pound of body weight in a 24 hour period. Give him 2 mgm. of thiamin and 100 mgm. of ascorbic acid each day until convalescence is accomplished.

If the diarrhea is not better in two days, even if it does not seem excessive, it is wise to admit the baby to the hospital because there is no sure way of knowing how nearly exhausted his intercellular fluid reservoir may be.

TREATMENT OF MODERATE AND SEVERE DIARRHEA

If the diarrhea is moderate or severe it presents a real pediatric emergency. The infant should be hospitalized and isolated; his disease is probably infectious and contagious and it is unwise to bed several babies with diarrhea in one room because they may each be infected with different pathogens. Take cultures and prescribe adequate chemotherapy if there are obvious signs of infection. All oral feedings, even water, must be discontinued. Begin treatment immediately and act quickly—in the admitting room if possible. The purpose of the therapy is twofold: to replace the water and electrolytes which the infant has lost and to supply, in addition, the infant's normal daily maintenance needs of these substances.

Replacement Therapy

A. Classify diarrhea as "moderate" or "severe."

B. Estimate weight loss, if not known, as 10-20 per cent of the body weight depending upon the severity of the diarrhea.

C. Give the following mixture at the rate of one half the estimated weight loss:

1 part M/6 sodium lactate
2 parts normal saline in 5 per cent glucose

This may be given by hypodermoclysis or, preferably, by slow intravenous drip.

D. If there are any signs of shock or if the diarrhea is severe, transfuse with cross-matched, whole blood—20 cc. per kilo (10 cc. per lb.). The transfusion must be given intravenously.

This replacement therapy is an emergency procedure to replace lost sodium and water, averting shock and restoring the circulation and renal function. The suggested mixture utilizes commercially available solutions and the amounts of sodium and chloride approximate those in extracellular fluid. The 5 per cent glucose supplies "free" water with which the kidneys can work, is of some caloric value and helps to combat ketosis. The blood transfusion is given in the hope of avoiding shock which may be irreversible. Whole blood may be given with safety even though the hemoglobin level is high. The lactate-saline mixture, if given intravenously, can be interrupted while the blood is transfused. It is important not to confuse commer-

cially available M/6 lactate solution with the concentrated M/1 solution which must be diluted before use.

Only one half the estimated weight loss is replaced since cellular disintegration accounts for approximately one half of this weight deficit and this loss can only be replaced during convalescence when new body cells are formed. For example, a 10 kilo (20 lb.) infant suffering from severe diarrhea loses approximately 20 per cent of his body weight or 2,000 Gm. He should be given 1,000 cc. of the lactate-saline mixture (1 cc. equals 1 Gm.) and should be transfused with 200 cc. (20 cc. per kilo or 10 cc. per lb.) of cross-matched, whole blood.

Maintenance Therapy

A. Give 50-150 cc. of the lactate-saline mixture, according to the size of the infant.

B. Give enough additional 5 per cent glucose to make a total fluid intake of 150 cc. per kilo (75 cc. per lb.) in the first 24 hours. This may be given by hypodermoclysis or, preferably, by slow intravenous drip.

This maintenance regime supplies only the normal infant's daily requirements of sodium and water and it must be given in addition to the replacement therapy. Recommended amounts of the lactate-saline mixture are based upon the fact that an infant according to his age (for instance, 6 to 18 months) needs from 0.5 to 1.5 Gm. of sodium chloride each day and the prescribed dosages supply the approximate equivalents of these amounts. Replacement and maintenance requirements are calculated separately here for clarity and convenience but the needed solutions should be combined and given together, by clysis or slow intravenous drip.

Therapy—Second Day

A. Is the baby better? Is his skin turgor good? Is he urinating? Has his diarrhea ceased?

B. If he is not better, it may be necessary to repeat the first day's replacement therapy in addition to the maintenance therapy.

C. If he is better, repeat the first day's maintenance therapy but now add 4 mEq. of potassium per kilo (8 mEq. per lb.) to the 5 per cent glucose.

Potassium is not given until the second day for two reasons: first, it is prudent to delay its administration until the infant is urinating and can excrete any possible excess, thus avoiding a harmfully high concentration of the electrolyte in the serum. Second, most of his potassium loss is from inside body cells and the infant presumably cannot utilize a replacement fund until convalescence begins and body cells are recreated. Potassium solutions are commercially available and the number of milliequivalents per cc. of solution is stated on the label. Potassium chloride as such, however, may be used (1 Gm. of potassium chloride equals 13.5 milliequivalents).

If twitching or convulsions appear they are probably the signs of low calcium tetany (calcium is lost in diarrheal stools and the citrate in transfused blood may depress the ionization of serum calcium); treat this tetany with intravenous calcium gluconate. Bear in mind that the amounts of water and electrolytes suggested here are approximations and watch the infant carefully; soft edema suggests that too much water has been given and hard, brawny edema suggests that the infant has received too much sodium. If the infant is not doing well at the end of the second day of therapy it is desirable to obtain blood chemistries and special consultation.

Therapy—Third Day

A. If the baby is better give the second day's maintenance therapy by mouth.

B. Feed no milk or solid foods while diarrhea, fever, nausea, vomiting or abdominal distention persist.

C. Milk must usually be omitted for two to five days.

To replace losses of water soluble vitamins, add 2 mgm. of thiamin and 100 mgm. of ascorbic acid each day to the therapeutic solutions and, upon the resumption of oral feedings, give these amounts by mouth. Because of the known difficulty with which a diarrheal infant absorbs fat, give vitamin K twice weekly by the parenteral route.

Convalescence

A. Resume feedings slowly—take a week or more to attain amounts which satisfy the infant's daily caloric needs.

B. Feed the infant one-half-skimmed milk with enough additional 5 per cent glucose to make a total fluid intake of 150 cc. per kilo (75 cc. per lb.) in each 24 hour period. Add one and one half tablespoons of sugar to each cup of milk used.

C. Fortify feeding mixture with 1 Gm. of potassium chloride daily until full caloric intake is attained.

One of the commonest errors in treatment is to increase oral feedings too rapidly. This will almost inevitably result in recurrence of diarrhea which will be even more difficult to control than the original attack. Resume oral feedings slowly!

SUMMARY

1. Diarrhea persists as an important cause of infant mortality and kills at least 7,000 American babies each year.

2. Most diarrhea in infancy is preventable and in any event, with proper treatment, it should not have a fatal outcome.

3. Treatment plans can be formulated which are simple and practical, do not usually need intravenous techniques or elaborate chemical determinations and can be carried out with commercially available solutions.

4. Such regimes are outlined.

THE EARLY RECOGNITION OF ENDOMETRIOSIS AND HORMONAL TREATMENT WITH TESTOSTERONE

JOHN M. FREIHEIT, M.D., F.A.C.S., *Waterbury*

The Author. *Chairman, Department of Obstetrics and Gynecology, Waterbury Hospital*

MEDICAL opinions state that fifteen per cent of women develop endometriosis during menstrual life. One-fourth of these develop metastic lesions in the rectosigmoid.

For the past five years I have been interested in the functional response of endometrial tissue to hormones. I feel that the functional study of ectopic endometrial response puts the control of the disease out of the experimental laboratory and the pathology department, right back into the clinical amphitheater where it belongs.

There are in general two types of endometriosis: (a) internal, which invades the uterine musculature and (b) external, which invades the serosa of the tubes, ovaries, the peritoneum of the cul-de-sac and uterovesical pouch, the rectum, the sigmoid, the appendix and the mesentery of the large and sometimes the small bowel.

External endometriosis is definitely not cancer. In internal endometriosis, cases of malignant degeneration in adenomyosis of the uterine wall have been reported by C. A. Castano[1] in 1940, Cirio in 1933,[2] and frequently endometrial implants in the rectosigmoid area have been mistaken for cancer. Most surgeons are now aware of the possibility of endometriosis in this area and the use of more frequent frozen sections has prevented a great deal of radical surgery. The majority of endometriosis that is seen however, is the external type, implantation around the tubes and ovaries and in the cul-de-sac. Goodall[3] has written two editions of a monograph on endometriosis. He very carefully describes variation in cellular structure into three types, stromatous endometriosis, stromatous endometriomata and acute endometriosis. He states, however, that the terms are purely relative, and calls the first two the chronic stages, those where cells lose their productive forms and become streamlined into more mature and even senile types. However, he concludes that the disease which occurs between the age of 23 and the menopause is a disease arising out of a neglected function of reproduction and is a product of our civilization due to late marriages and later conceptions, because so often endometriosis is seen after long periods of infertility after conception. Nevertheless, the same author states that ovaries afflicted with endometriosis are in his opinion "unusually prolific ovaries filled with ova and with the products of developing matured with defective follicles."

Why these discrepancies? Is it possible that the cause of this prolific hyperplasia of ectopic endometrium has its inception in functional hormonal changes that may occur at any time after pregnancy as well as in the female whose reproductive functions have been thwarted by late marriage? Curiously enough, both these situations seem relatively frequent in reviewing the cases of endometriosis with which I am familiar.

Although the symptomatology of endometriosis has always been associated with menstrual function, reports of the effect of hormones on this disorder are rare. Morse concludes his paper with the advice that the use of estrogenic therapy after operating upon cases of endometriosis is better avoided if possible, as the implants remaining may be thus activated. Goodall states that the "acute" types of endometriosis "bespeaks an active, powerful agency stimulating specific cells to growth and to a capacity to break through the bounds of normal environment." He further postulates, "we are reduced to considering the endocrine functions of the ovary as the immediate cause of endometriosis and its allied diseases, most of the manifestations accompanying endometriosis are of the nature of hypertrophy, and hyperestrinization is another interesting clinical feature." Yet despite these theories, nowhere does Goodall present any data on the effect of hormonal stimulation on the clinical picture. In 1944, James R. Miller[4] wrote on the effect of testosterone in reducing the size of endometrial implants in the cul-de-sac and the sigmoid, preliminary to performing a radical operation on the rectosigmoid. John C. Hirst in 1945 reported that testosterone proprionate therapy had improved the symptoms of fourteen patients with endometriosis, both external and internal. He gave a monthly maintenance dose of 300 to 400 mg. of methyl testosterone per os following one month in which 200-300 mg. were given intramuscularly. He reports masculinization symptoms, however. Salmon[5] and all the manufacturers of testosterone state that testosterone in doses up to 200 mg. per month relieve the symptoms of endometriosis. They carefully state, however, that testosterone does not cure the condition. In 1949, the author of the present communication called attention to a hormonal test for endometriosis with estrogens. The essential matter of this is here restated. If testosterone gives such good results in deactivating the ectopic endometrium, it seems reasonable to believe that hyperestrinization could be used as a diagnostic agent. No natural hormone hypodermically causes any "explosive" reaction physiologically and as a rule, two or three months elapse before primary functions are appreciably affected. As early as 1940, Fuller Albright[6] described the mechanism of estrin therapy in the relief of dysmenorrhea. In certain cases of functional dysmenorrhea, Sturgis and Albright showed that the presence of a normal corpus luteum is a prerequisite for the occurrence of dysmenorrhea and hyperestrin therapy prevented cramps by arresting the development of a functioning corpus luteum during that cycle. To quote, "This study is based on a series of twenty-five cases. These patients with one or two exceptions had severe distressing dysmenorrhea frequently forcing them to miss one to three days from their work." Throughout the study, the patients received 10,000 units of estrodiolbenzoate intramuscularly every third day. A series of injections depended entirely upon how soon in the month the injections were started. If the first of a series of from six to twelve injections was given within the first week after onset of menses, the next period was invariably free from cramps. If the series was not started until two weeks after the onset of the previous flow, there was no change in the pains during the subsequent bleeding. It was next noted that although a completely cramp-free period followed a course of estrin given early in the cycle, yet the next period, if the course of estrin was omitted, was just as painful as ever.

Needless to say, these authors then took endometrial biopsies and proved that these patients with essential dysmenorrhea had secretory endometrial patterns, evidence that ovulation had taken place. When endometrial biopsies were taken after an early series of estrin injections, the endometrial biopsy before the following cramp-free period showed a proliferative pattern, evidence that corpus lutein formation was repressed. In the same manner, endometrial biopsies in a succeeding month without further estrin therapy showed that estrin treatment one month did not repress or inhibit ovulation the next month.

I first became interested in this hormone method of treating dysmenorrhea around 1940. A series of patients with essential dysmenorrhea was treated with estrin with good results, then cutting the dosage from 30,000 to 50,000 units a week to 2,000 to 4,000 units per week. I found that many remained pain free on the smaller doses and then began to find an occasional patient on whom small doses of estrin seemed to increase rather than to improve the dysmenorrhea. After several months pelvic induration was progressive and exploratory laparotomy revealed an extensive endometriosis. This episode, necessitating a complete pelvic operation, made me suspect that I should have recognized this condition earlier. The interesting feature of this incident was the part that small doses of estrin played in bringing

out the objective signs of endometriosis. Another case which verified this phenomenon was an infertility patient with no demonstrable pelvic pathology, but an intractable dysmenorrhea. Small doses of estrin, after the usual large doses to prevent ovulation again, had a tendency to increase the dysmenorrhea. After three months observation during which time tubal inflation showed both tubes open, this patient developed an acute appendix. This was confirmed at laparotomy and there was also a well defined endometriosis with adhesions, but no marked induration. I removed the right tube and ovary with the appendix which was unruptured. The left ovary and the tube were free but there were several small implants in the left adnexal area. These could not be removed and as usual with the infertility patient the uterus and left tube and ovary were not disturbed. The patient was symptom free of dysmenorrhea for two months, and then began to complain again. There was some tenderness in the left adnexa and I think I presumed rightly that the endometriosis was flaring up in this area. Accordingly I gave 100 mg. of testosterone per week for about six months and then continued 25 mg. weekly for two years. This patient continued the treatment faithfully, because she knew the danger of losing the other tube and ovary. She had changed remarkably over this period. She was thin, nervous and excitable and now has become stouter, has no masculine changes but lost the nervous tension and excitability which characterized her previous phase. There is no more dysmenorrhea and I am prepared to state that she has no more endometriosis because her adnexal regions are completely free. She has not become pregnant. Therefore, one might infer that testosterone acts as a deterrent to pregnancy. Yet if one considers another endocrine disorder, namely menopausal bleeding due solely to a hyperestrogenic reaction at or near the menopause, and treats this condition with testosterone in moderate doses, not only does the hyperestrinism clear up and bleeding become regular, but many of these patients find their fertility revived, following the discontinuance of testosterone. The last patient I saw in this situation was much incensed about it and she finally found a New York specialist who aborted her for otosclerosis complicating the pregnancy. She was kind enough to call me and remind me that I knew she was a little deaf and inferred that I overlooked this danger to her health and happiness.

Nevertheless, testosterone therapy at this phase does not prevent pregnancy at a time when its inc dence would normally be expected to be on tl wane. Why should it do so in moderate dosages 25-50 mg. per week early in the childbearing perio

In my previous paper I described a young patie with endometriosis associated with obstruction in congenitally deformed uterus and I wish to resta this case and include an interesting follow-up.

A twenty-two year old graduate nurse was seen last ye with a complaint of increasing dysmenorrhea of two yea duration. Her periods began at 15 and until 20 were pra tically pain-free. Then she began to have dysmenorrhea un she had to be confined to bed the first three days of ea period. Sedatives were ineffective. Rectal examinati showed that she had a single cervix and what appeared be an infantile uterus with two thickened masses suggesti of enlarged tubes in either adnexal region. In the absen of any temperature reactions or history of infection, it w considered that these swellings were either a congenit uterus or an advanced endometriosis of the ovaries. Th patient refused vaginal examination under anesthesia. Th use of estrin as outlined above for two months made th dysmenorrhea more severe. The use of testosterone 25 m weekly gave no relief. Finally the patient consented t examination under anesthesia and exploratory laparotom On vaginal examination a narrow vault with a septum on th left made a congenital deformity a distinct probability. Ther was a single cervix, however, and probing showed th uterine body to the right and a mass felt in the left adnex was thought to be tubovarian. Exploratory laparotom showed a complete uterus bicornus didelphys with sever adhesions around the left ovary which were associated wit mild endometriosis. Several small implants with dark cer ters, the largest 0.5 cm. in diameter were noticed on th surface of the left ovary and on the peritoneum of th cul-de-sac. The development of both horns of the uterus wa equal and both were symmetrical. Both tubes were pate to gentle probing. Accordingly the endometrial implant were carefully dissected free and while it was assumed tha in an extensive congenital deformity such as this the uteru was probably supplied through the ureteral sympathetic as well as the presacrals, nevertheless a presacral sympa tectomy was performed. Recovery was rapid but the suc ceeding periods were just as painful as previously. Testo sterone was given in 25 mg. doses weekly and still there wa no effect on the dysmenorrhea. Most of the discomfor seemed to be left-sided since the operation, however, an remembering that the endometriosis had been around th left tube and that dilation and curettage before the firs operation had allowed probing of the right horn of th uterus it was felt after three months of poor postoperativ result that the uterus should be studied with lipiodol injec tion. The patient was willing to have further studies mad and under sodium pentothal anesthesia the cervix was ex posed and drawn into working position with a tenaculum The right horn of the uterus was easily probed with uterine sound, but with no type of probe could the opening to the left uterine horn be discovered nor was any othe aperture into this side found. After about fifteen minute

futile probing, lipiodol was injected into the cervix rough a cervical canula under about 180-200 mm. pressure mercury. About 8 cc. of oil was injected for the first ite and 14 cc. for the second. The roentgenograms showed e right uterine horn and the right tube patent but no oil d entered the left horn or the left tube. Evidence was w conclusive that drainage from the left side of this con-nital uterus was blocked and that the endometriosis was e to a retrograde spill through the left tube due to in-ility of the endometrium to pass in the normal direction. is also explained the failure of testosterone to relieve the smenorrhea. Whether the progressive dysmenorrhea was e result of gradual blocking of the imperfect cervical erture from the left horn by endometriosis or whether e left horn developed later in this girl than the right and en tried to function with a blind os is a matter of conjec-re, though the amount of induration in the cul-de-sac ther favored the fact that the endometriosis caused com-etion of the block. With the evidence of complete lack function of the right side this patient was encouraged to low the removal of the left horn and adnexa if patho-gical, and promised to preserve the functioning side in e hope of eventual pregnancy.

Accordingly the old scar was excised under continuous inal anaesthesia and the abdominal cavity opened without fficulty. There were very few adhesions. The two horns the uterus were still the same size although numerous esh areas of endometriosis were present around the left vary and the left broad ligament. There was a large indur-ed area of endometriosis in the cul-de-sac near the portion the lower left uterine segment which originally con-ined the os and cervical canal. The right side was singularly ee of endometrial implants. The left horn was grasped ith a tencaculum and drawn upward and medially. The road ligament was very short. The left ovary contained ne small chocolate cyst and several small endometrial nplants. The left round and infundibulo-pelvic ligaments ere tied separately with two chromic and divided to the terocervical junction. Here some difficulty was encountered n finding the uterine arteries. One was finally located nteriorly, a branch of the cystic vessels, and another came osteriorly and was evidently a branch of the inferior nesenteric. The left ureter was at the base of the leaves of ne broad ligament and care was taken not to injure it. By eeping close to the lower segment, the vaginal vault was pened. The bladder flap was dissected free across the bridge f the uterus didelphys and pushed downward by blunt issection including that mass in the cul-de-sac which ap-eared to be an endometrial implant. The entire left side f the congenital uterus was thus dissected from the right ortion close to what appeared to be the cervical portion of he right horn. The uterine arteries were transfixed and tied nd the vaginal vault closed with interrupted chromic utures. The left round and infundibulo-pelvic ligaments vere transfixed to this portion of the vault with No. 1 hromic and sulfanilimide powder introduced over this losure. The bladder flap was drawn over this area with a nattress suture of No. 1 plain. As many of the endometrial mplants as possible on the left side were freed by sharp nd blunt dissection with scissors. All visible endometriosis areas were removed. While it was impossible to feel that all endometriosis in this area was removed, it was felt that the remainder might be controlled by the testosterone. The right horn and tube and ovary were left in situ. Further explora-tion was negative and the abdomen was closed routinely. Seven days after the operation the patient had her first painless period in two years. Twenty-five mg. of testosterone were used weekly the first two months and this terminated her follow-up at the time of writing in 1947.

This patient was continued on testosterone for one year with a dose of 25 mg. weekly by hypo-dermic. She had no further dysmenorrhea. One year afterward she became pregnant in the remaining right horn of the uterus, and after carrying the pregnancy for four months suddenly aborted. Secundines were removed and testosterone con-tinued. Twelve months later she again became pregnant and in view of the previous abortion she was given progressive stilbesterol therapy to 120 mg. per day. At thirty-two weeks the cervix was obliterated and very soft and two finger breadths dilated. The stilbestrol was stopped and the patient went into labor spontaneously on the thirty-third week and delivered a six and one half pound female child in three hours. The third stage was normal, the placenta was easily expressed intact with minimal bleeding and after perineal repair the patient had an uneventful puerperium. She has remained symptom free of dysmenorrhea and without any localizing signs of endometriosis for several months without treatment. Two other young patients in the last five years who each had one tube and ovary remaining with the uterus after operation for early endo-metriosis and who continued testosterone therapy have become pregnant and delivered normally, but neither was as striking as the above case. Conse-quently, when a woman in a childbearing period with early endometriosis improves with testosterone therapy and still fails to become pregnant attention should be directed to the husband as a factor in the infertility problem.

I used to feel that the recurrence of endometriosis in a woman of the childbearing age called for the use of x-ray or radium to cause complete cessation of ovulation to cure the endometriosis. Now I am beginning to doubt that this is necessary although such authorities as Meigs and Taylor indicate that this is the only alternative to the operation and the preferable procedure. In one well known clinic re-current endometriosis of this type is always treated by complete removal of ovarian tissue operatively; x-ray and radium are never used.

How far can we go with testosterone? I have always been alarmed at the possibility of masculinization, and professional confreres as well as the patients' husbands have shown concern when the mention of testosterone is made. Now the question arises, is a little temporary masculinization better to control endometriosis than the alternate procedure of castration? I have been pondering this for some time until I had a recent communication with Dr. Christie of Calgary, Alberta. Dr. Christie reports a case that demands serious consideration. This was a patient who left Canada with her husband to do missionary work in South Africa. While there she developed some dysmenorrhea and excessive bleeding and had an exploratory laparotomy where it was discovered that all her pelvic organs were bound down by an "unoperable malignant growth." Diagnostic sections were taken and the abdomen closed. The pathological report was endometriosis. The surgeons wanted to do further operative procedure but the patient refused and said she was going to wait until she got back to Calgary. She sent the slides and pathological report to Dr. Christie who confirmed the findings. The latter, who felt that it would be some time before the patient could return, and thinking of discussions we had on the subject, sent her patient some testosterone and told her to have the clinic nurse give her 200 mg. a month, and this might prevent the spread of the lesion while waiting to return to Canada.

For some reason it was one year before she returned and then Dr. Christie reports that she was greatly surprised at the patient's appearance. Instead of the thin woman she had known previously, the patient was stout, had hirsutism and a deep masculine voice, complete suppression of menses *with complete relief from symptoms of dysmenorrhea.* It was confirmed that the patient had faithfully continued the 50 mg. per week for the entire year by intramuscular injection.

The surprising part of the matter, however, was that on a pelvic examination the patient was entirely free of any evidence of pelvic induration or disease. X-ray showed normal contour of the bowel.

The patient was advised to discontinue testosterone and normal menstruation recurred one month later. Her BMR at this time was −24. With small doses of thyroid which were discontinued after a few months the patient's present health is splendid. Signs of masculinity have entirely disappeared and menses are normal without pain. Pelvic and rectal exams are normal.

If complete recovery occurs with large doses of testosterone in extensive lesions, should we not be able to influence the development and cure early lesions with similar treatment? I feel that the cases I have described in this paper have shown this tendency to cure with testosterone, and that it is a challenge to the gynecologist to make early diagnosis of potential endometriosis. Just as the recognition of corpora-luteal disorders of the right ovary cut down on the incidence of appendiceal operations, so the recognition of early endometriosis will diminish the incidence of destructive operations during the childbearing period on ovaries which might still be capable of reproduction.

I began this paper with a statement of opinion about the percentage incidence of endometriosis. I should like to emphasize that symptoms due to endometriosis may be alleviated by injections of androgens, and I feel that prolonged treatment with testosterone will cure many cases of this disease especially in early stages. I believe that the best method of administration is hypodermically for this prolonged period. Too many people have reactions to oral or buccal administration to warrant such use. Too often a patient forgets self administration whereas the administration by hypodermic should cause no more concern than a daily administration of insulin. The duration of treatment to effect cure will be between twelve and twenty-four months. The occurrence of amenorrhea or a few masculinization symptoms should not discourage the continuation of the treatment for such symptoms will completely subside after the aberrant endometrial tissue is kept in a state of rest for a long enough period to allow regression to occur and the hormone is finally withdrawn.

BIBLIOGRAPHY

1. Castano, C. A.: Bol, Soc de Obsyginee de Buenos Aires, 19:266, 1940.

2. Cirio, C. R.: Rev. S. Amer. de Endocinology, 16:555, 1933.

3. Goodall, J. R.: Mono. "Study of Endometriosis," 2nd Ed. Lippincott, Phila.

4. Miller, J. R.: J. A. M. A., 125:297, 1944.

5. Salmon, U. J.: "Progress in Gynecology," 1946. Grune and Stratton, Publishers.

6. Albright, F., and Sturgiss: Endocrinology, 26:68, 1940.

7. Freiheit, J. M.: Conn. State Med. Journ. XI; 12, 965, 1947.

THE CONTROL OF CONVULSIVE SEIZURES BY ENDOCRINE THERAPY
(A Preliminary Report)

MAURICE R. MOORE, M.D., F.A.C.P., *Norwich*

EPILEPSY is a common cause of convulsive seizures. There is no general agreement as to the etiological factors in idiopathic epilepsy but there may be some basis for the belief that abnormalities of endocrine function are among them.

If so, then steroid hormones might be expected to have some effect in correcting the abnormality. Research has shown that steroid hormones possess anesthetic properties which bring about muscular relaxation. For example, the intraperitoneal injection of 10 mg. of progesterone into a 70 Gm. rat produces profound anesthesia with marked muscular relaxation.[1]

An anticonvulsive property has been demonstrated in animals for desoxycorticosterone, testosterone, progesterone and diethylstilbesterol.[2,3] Pregnenolone and acetoxypregnenolone also possess this property.[4] In a study of 29 steroids, Spiegel and Wycis[5] found that those manifesting definite anticonvulsive effects were either sex hormones or adrenal substances.

Clinically, desoxycorticosterone has protected patients with convulsive disorders against the convulsive effects and alteration in electrolyte balance produced by pitressin.[6] It also has reduced the frequency of grand mal and petit mal attacks in epilepsy of iodiopathic or post-traumatic origin.[7-9] Sucker has published a case report of an epileptic male who was greatly improved following the administration of crystalline estrone. The use of stilbestrol in epilepsy also has been reported.[11]

I would like to report on 2 cases of idiopathic epilepsy which responded to endocrine therapy. The first case occurred in a 63 year old male in whom convulsive seizures were associated with episodes of hypoglycemia. Treatment consisted of injections of male and female sex hormone in a balanced ratio, along with a high protein diet and high vitamin intake. The second was a case of nocturnal epilepsy in a 13 year old girl in whom male and female sex hormones and progesterone brought about improvement.

CASE 1

A 63 year old, white, Polish, tavern proprietor. *Present Illness:* In September 1945 the patient had an episode of unconsciousness shortly after awakening. The attack lasted about fifteen minutes during which time he had convulsive seizures, cried out, bit his tongue and lip and had urinary incontinence. In a fall he incurred a small ulceration on his left forehead that healed without complications.

The patient had five succeeding episodes, the first after an interval of one year and the remaining four at intervals of approximately three months. The last attack occurred five weeks before seeking medical advice. The patient remembered nothing that occurred during the episodes. On one occasion he had nocturnal urinary and fecal incontinence. One of the five attacks occurred in the afternoon, the others during the night or upon arising. There was no aura, no headache, and no associated tinnitus or deafness.

Almost daily attacks of vertigo, during which the patient was forced to sit and hold on to a chair to prevent pitching forward on his face, commenced shortly after the first convulsive seizure. No vertigo, however, had been experienced in the past three months. He had frequent crying spells and felt sad without knowing why.

There has been a choking sensation on the left side of the throat and excess salivation which awakens him at night. He has felt fatigued and weak with loss of ambition, loss of appetite and weight, nocturia two to three times nightly, increased diurnal frequency, and some slowing of the urinary stream. During the past five years a small, subcutaneous growth has been present in the lower back region. In the past three months it has enlarged to the size of a small orange.

History: His parents died at ages over 60, one sister at age 65, and three brothers have died of causes not known to the patient. One sister, age 48, is living and well. The patient knows of no familial tendencies.

The patient came to the United States of America from his native Poland in 1901 at the age of 17. He has lived since then in New England. He is able to continue his occupation as tavern proprietor. He has been married forty-three years and has five children, all of whom are well, ranging in age from 30 to 39 years.

He recalls no childhood diseases, has had no serious illnesses, operations, accidents or injuries. He uses no tobacco but drinks 6 to 7 glasses of beer and one cup of coffee daily. His diet is adequate. He has eliminated fats on the advice of a physician, sleeps normally except when his symptoms waken him and denies the habitual use of drugs.

Physical Examination: Temperature 98.8; pulse 80 to 120; respirations 20; weight 148 lbs.; height 5′5½″. The patient is a well developed, apparently well nourished male of 63 who does not appear ill. *Skin:* Numerous senile keratoses over the body; a few nevi in the left lower lumbar region posteriorly, and a soft, movable subcutaneous mass, about the size of a small orange, which appears to be a lipoma is found there also. *Eyes:* The left pupil appears slightly irregular, and grade 2 sclerosis of blood vessels is present,

but no hemorrhages or exudates. *Neurological:* All superficial and deep reflexes are intact and equal bilaterally, except that the ankle jerks are not definitely obtained even after reenforcement. There is no impairment of sense modalities or motor strength. *Mental status:* Behavior, speech and mood are normal, except for a crying spell while giving history. Memory is good; he is able to remember dates with no apparent difficulty. Physical examination produced nothing else of note.

Laboratory data: E. C. G. 1/17/48. Rate 75-80; rhythm sinus. Conclusion: Anomalous atrioventricular conduction. Wolff-Parkinson-White pattern in Leads 2 and 3 and in chest lead. Another, less likely conclusion is "coronary" rhythm (Pro. 12) with intraventricular block with partially iso-electric QRS complex in Lead 1. *X-ray of the chest and skull:* Negative. *I. V. Pyelogram:* Negative. Elevation of bladder floor suggests prostatic enlargement. *Urine:* Normal. *Blood and differential count:* 1/16/48: Hgb. 96 per cent 15.0 Gm. per cent; R.B.C. 4.58; C.I. 1.04; W.B.C. 5 500. Total P.M.N. 66 per cent; bands (1 per cent); lymphocytes 23 per cent; monocytes 10 per cent; basophiles 1 per cent. *Blood smear:* Normal. *Blood Chemistry:* 1/17/48. Bilirubin 1.5 mg. per cent; phosphates, acid (King) 1.7 mg. per cent.

Six hour blood sugar tolerance test: (100 Gm. glucose).

Blood sugar		Urine sugar	
Fasting	113	Fasting	Negative
½ hour	177	½ hour	Very faint trace
1 hour	134	1 hour	Very faint trace
2 hours	114	2 hours	Negative
3 hours	86	3 hours	Negative
4 hours	88	4 hours	Negative
5 hours	98	5 hours	Negative
6 hours	116	6 hours	Negative

Blood sedimentation rate: 1/17/48: 20 min., 7; one hour, 25. *Serology:* Negative. *Stools:* Negative. *Spinal Fluid:* Appearance, clear and colorless; pressure 130 mm.; lymphocytes 0; R.B.C. 0; gold sol. 0000000000; Davies Hinton, negative; Wasserman ------; protein 29. *Liver function tests:* 1/19/48: 30 min. 13 per cent; one hour, 8 per cent. *Basal Metabolism Rate:* Plus 4.

Diagnosis:

1. Convulsive state, undetermined etiology.
2. Benign prostatic hypertrophy.
3. Question of early liver pathology.
4. Lipoma, left lower lumbar region.

Treatment: A low fat, high protein diet, with milk and crackers at bedtime was prescribed. In addition one Zymacap capsule and one Surbex with vitamin C tablet were to be continued indefinitely. One Iberol tablet was used daily for three months, then discontinued.

Initially 1½ gr. Dilantin was given three times daily after meals, the dosage gradually reduced to 1 gr. daily, and discontinued after one year.

In addition the patient received male hormone in the form of 25 mg. Oreton* (testosterone propionate in oil) per week by intramuscular injection. This amount of hormone caused sexual excitement. Therefore approximately 1 mg. (6000 R.U.) Progynon B (estradiol benzoate) was added to neutralize the sexual effect. The excitement disappeared and the patient experienced a sense of well being.

*Manufactured by Schering Corporation, Bloomfield, N. J.

DISCUSSION

With treatment the pulse rate soon became normal, the blood pressure decreased and maintained an average of 125/80, and the patient was not nervous. Spacing of the Oreton injections was changed from one week to one in four weeks, depending on the findings at the time of examination and on the patient's behaviour. Occasionally six weeks elapsed between injections. The patient would then be disturbed, have a rapid pulse and elevated blood pressure, and come to the office weeping. These symptoms promptly responded to weekly injections of Oreton and Progynon B, the interval between injections being lengthened to four weeks as soon as the patient's condition warranted. With this care the patient has had no convulsive seizures during the past three and one half years and has maintained his business.

This case of episodes of hypoglycemia associated with convulsive seizures and symptoms typical of the male climacteric is considered to have responded satisfactorily to a high protein diet, a high vitamin intake, and injections of balanced male and female hormone. The seizures disappeared and the patient continued his occupation.

CASE 2

A 13 year old white girl.

Present Illness: At age 12 the patient developed episodes of semiconsciousness occurring near midnight and described by the mother as "nightmares." She left her bed and walked around the room. When the lights were turned on, she crouched in a corner or stood and stared, failing to respond to conversation. Once she climbed into the bathtub, clad in her nightgown, and scalded her feet by turning on the hot water. The following morning she recalled the incident only dimly.

Family History: The mother has been given to so-called hysteria; her menstruation began at age 11. An 11 year old sister was found to have glycosuria, hypothyroidism and precocious development. A brother has experienced delayed development.

Physical examination: A shy, highly nervous, poorly developed, 13 year old girl who responded poorly to questions and grinned whenever conversation was attempted. Weight 92 lbs.; height 60"; blood pressure 110/50; pulse rate 100. The cervical glands were small, the thyroid palpated with difficulty. The heart beat rapidly, but no murmurs were heard. The mammary glands were undeveloped, the genitalia not unusual, but the pubic hair scanty for her age. Menstrual cycle varied from 23-28 days. Menstruation would at times continue for two weeks, the patient experiencing

heavy flow, cramps and nausea during the first half of that time. The examination was not otherwise remarkable.

Laboratory data: B.M.R. -6. *Blood count:* R.B.C. 3.84; Hgb. 12.4 Gm. per cent. *Urinalysis:* Normal. *Glucose Tolerance test:* (100 Gm. sugar orally). Fasting blood sugar 66 mg. per cent. Urine sugar negative. One hour blood sugar 86 mg. per cent. Urine sugar negative. Test discontinued after one hour because of weakness and nausea.

Treatment: The patient was put on a low fat, moderate carbohydrate diet and was awakened at 11 o'clock each night for a glass of milk with bread or cracker. Thyroid 1/10 gr. daily was started and adequate amounts of vitamins A, B, C and D introduced.

Following initial treatment, the "nightmares" disappeared and have not returned. The child gained moderate self-confidence and made above average progress at school. After nine months she was so well the thyroid was discontinued. The late evening meals and vitamins were continued.

After six months without thyroid the patient grew irritable and nervous and complained of precordial distress. The previous regimen with larger doses of vitamin B and C was reinstituted. Thyroid could not be increased to ¼ gr. daily because of the development of a rapid heart rate. In order that the increased thyroid might be tolerated, hormone injections were given according to the following table:

DAY OF CYCLE	INJECTION USED
1ST MENSTRUAL CYCLE	
5th, 12th and 17th days	*Progynon B (Estradiol benzoate) 1.66 mg.
24th day	Estrogenic substances 10 000 I.U. *Proluton (Progesterone) 10 mg.
2ND MENSTRUAL CYCLE	
5th day	*Progynon B (Estradiol benzoate) 1.66 mg.
12th and 19th days	*Progynon B (Estradiol benzoate) 1.00 mg. Testosterone 10 mg.
24th day	Estrogenic substances 10 000 I.U.
3D AND 4TH CYCLES	Estrogenic substances 10 000 I.U.
14th day	*Progynon B (Estradiol benzoate) 1.66 mg.
21st day	Estrogenic substances 10 000 I.U. *Proluton (Progesterone) 10 mg.

DISCUSSION

This case may justly be called nocturnal epilepsy. Three and one half years have passed under treatment without an episode. The patient has changed from a child to a young woman 61¼ inches in height and weighing 116 lbs. Menstruation occurs regularly at 28 days with five day periods and a slightly scanty flow.

The hormones produced a marked change in the patient. The mammary glands developed normally and hips and legs also developed. The patient assumed an attitude of confidence and self assertion. Her nervousness was markedly reduced. The pulse rate returned to normal and ¼ gr. thyroid was well tolerated. It is being continued as a glandular stimulating agent.

*Manufactured by Schering Corporation, Bloomfield, N. J.

SUMMARY

Support is lent to the theory that an endocrine imbalance may be an etiological factor in epilepsy by the disappearance of episodes in two cases of idiopathic epilepsy receiving male and female sex hormones. Convulsive seizures associated with episodes of hypoglycemia and male climacteric symptoms were abolished in a 63 year old male who received a high protein diet, vitamins, dilantin for one year, and a balanced ratio of male and female sex hormones. A 13 year old girl with hypoovarianism, who was subject to epileptic episodes, developed normally and was no longer subject to attacks after treatment with thyroid, vitamins and sex hormones at appropriate times during the menstrual cycle.

BIBLIOGRAPHY

1. Selye, H.: Pharmacologic terminology and classification of the steroids, Textbook of Endocrinology, Montreal, Acta Endocrinologica, 1947, pp. 58-9.

2. Spiegel, E.: Anticonvulsant effects of desoxycorticosterone, testosterone and progesterone, Fed. Proc. 2:47, 1943.

3. Kral, F.: Epileptiform manifestations of endocrine disturbances associated with adrenal tumors, J. Am. Vet. M. A. 118:235, 1951.

4. Marks, M., and Spiegel, E. A.: Anticonvulsant effect of pregnenolone, Fed. Proc. 5:71, 1946.

5. Spiegel, E. A., and Wycis, H. T.: Anticonvulsant effects of steroids, J. Lab. & Clin. Med. 30:947, 1945.

6. McQuarrie, I., Anderson, J. A., and Ziegler, M. R.: Observations on the antagonistic effects of posterior pituitary and corticoadrenal hormones in the epileptic subject, J. Clin. Endocrinol. 2:406, 1942.

7. Gordon, G. S., and Aird, R. B.: Sublingual desoxycorticosterone for the control of convulsive seizures, Ciba Clin. Symposium 3:57, 1951.

8. McQuarrie, I.: Observations on the therapeutic effect of desoxycorticosterone acetate in epilepsy, Am. J. Dis. Child. 72:472, 1946.

9. Aird, R. B., and Gordan, G. S:. Anticonvulsive properties of desoxycorticosterone, J. A. M. A. 145:715, 1951.

10. Sucker, A.: Behandlung der genuinen epilepsie mit weiblichen sexualhormonen, Schweiz. med. Wchnschr. 77:224, 1947.

11. Hancock, R. C. G.: Stilbestrol and its use in epilepsy, Vet. Rec., London 55:75, 1943.

THE EFFECT OF PREMEDICATION OF CORTISONE ON THE HEALING OF WOUNDS IN AN INFANT

ALBERT RUBIN, M.D., and MOSES D. LISCHNER, M.D., *Hartford*

THE literature, to date, regarding the effect of ACTH and Cortisone on the healing of wounds has been confined to demonstrations on animals. It has been shown experimentally that Cortisone and ACTH lead to suppression and/or slowing of formation of connective tissue in cases of trauma.[1] In a set of controlled experiments on rabbits, a group of normal rabbits was pretreated with 25 mgm. of Cortisone for 3 days. Skin defects were made in the ears using the method described by Howes. Similar defects were made in the ears of rabbits not pretreated with Cortisone, serving as a control group. The rabbits were killed 5 to 8 days after the ear wounds were made. The control animals showed new granulation tissue covering the blood vessels and a profuse growth of all the elements of new connective tissue such as fibroblasts, blood vessels and ground substance. The group of pretreated animals showed no evidence of granulation. The blood vessels were covered only with a thin layer of fibrin. New fibroblasts and blood vessels were rare. Ground substance, as determined by toluidine blue and Hale stains was much less in amount than in the control rabbits. There was a slight amount of epithelium at the edges. In a third group, when the dose of Cortisone was reduced to 5 mgm. (which corresponds to the therapeutic dose for humans), there was a delay in the appearance time of granulation rather than a complete suppression of healing. Granulation began to appear on the 8th day.

It has also been shown that ACTH and Cortisone caused thinning of the epidermis and atrophic changes in the adipose layer and the sebaceous glands in the area of the wounds.[2] There was greater tendency toward hemorrhage in the line of incision and the epithelium did not unite firmly until the 10th day, whereas in the control animals, this period was from 4 to 7 days.

The effect of ACTH and Cortisone on the repair of all elements of connective tissue is similar to that seen in scurvy.[3] The ascorbic acid level of plasma in Cortisone-treated rabbits appears to be somewhat lower than that in the controls. Cortisone has also been injected into mice to determine the effect on healing of traumatized tissue.[4,5] One mgm. was injected twice daily and 24 hours later the mice were wounded. After 5 days, a control group showed considerable compact, well vascularized granulation tissue. The C-treated mice showed scant collections of fibroblasts. However, there was complete epithelialization in some of this group. The spleens of this C-treated group were smaller than those in the controls. When Cortisone was administered 48 hours after wounding and its use continued for 5 days, there was no significant difference in quantity and quality of the granulation tissue.

CASE REPORT

Baby D. M., a 6 month premature infant was the survivor of a twin birth, delivered 12-17-50. She was born with retrolental fibroplasia and two hemangiomata, one on the back of the neck and the other on the anterior aspect of the left shoulder. The neck lesion was about the size of a quarter and elevated about 3/16 of an inch. The shoulder lesion was pea sized and slightly elevated.

Cortisone in raspberry syrup was given daily, while the infant was in the hospital, 2/26/51, through 3/11/51, in doses varying from 50 to 100 mgm. per day for treatment of the retrolental fibroplasia.

DOSAGE

2/26	100 mgm.	
2/27	75 mgm.	daily
3/4, 5, 6	100 mgm.	

On all other days of hospitalization, 50 mgm. was given daily. Chloromycetin, in dosage of 50 mgm. daily was given from 2/10 to 3/11. Penicillin, 100,000 units, was administered on 2/10, 11, 12, 13. A small blood transfusion was given on 2/10.

The baby weighed 2 lb. 7 oz. at birth on 12/17/50. On discharge from the hospital on 3/1/51, 6 lb. 5½ oz. On 3/26 the weight had increased to 7 lb. ¼ oz. the patient continued to receive 50 mgm. of Cortisone daily, until 3/22, when the dose was increased to 50 mgm. b. i. d. This dosage was continued until 3/30, when the use of Cortisone was discontinued.

Dry ice was applied to the hemangiomata on 2/20, before the institution of Cortisone therapy and again on 3/7, after

it had been in use for 9 days. When the baby was seen on 3/22 the shoulder hemangioma was unchanged and the lesion on the neck showed a small central ulceration the size of a lentil. For this, penicillin ointment and boric acid compresses were used. The baby was next seen on 4/9, 33 days after the first application of dry ice and 10 days after the cessation of the use of Cortisone in 100 mgm. daily dosage. The hemangioma on the neck presented a large round, craterlike ulceration the size of a nickel. Inside the crater was a deep, bright red, clean, corrugated lesion oozing a thin, serosanguinous fluid. There was an area of redness around the entire area which was very painful and tender. The edges of the crater were elevated with a ruffled, mushroom-like appearance. There was no apparent tendency toward granulation or healing. Boric acid compresses and aureomycin ointment were applied. By 4/18, the ulceration was completely healed and the last adherent scab fell off. This was 19 days after the cessation of Cortisone therapy which had been discontinued on 3/30. The patient was seen again on 5/7 and on 6/21. The hemangiomata were present but were smaller and paler.

CONCLUSION

A case is presented which shows an unusual ulceration of a hemangioma treated with dry ice. Small doses of Cortisone (50 mgm. daily) produced a small ulceration which did not heal. Doubling the dosage produced a large ulceration which did not heal so long as Cortisone therapy was maintained. There was complete healing 19 days after the cessation of Cortisone therapy.

The use of aureomycin ointment and penicillin ointment had no effect on healing of the ulceration so long as Cortisone therapy was maintained.

REFERENCES, BIBLIOGRAPHY

1. Rogan, C., Howes, E. L., Platz, C. M. et al: "The Effect of ACTH & Cortison on the Connective Tissue." Bulletin of the New York Academy of Medicine, page 151, April 1950.

2. Baxter, H., Sciller, C. et al: "Influence of Cortisone on the Skin and Wound Healing in Experimental Animals." Journal of Plastic Reconstructive Surgery, page 25, January, 1951.

3. Rogan, C., Howes, E. L., Platz, C. M. et al: "The Effect of Cortisone on the Production of Granulation Tissue in the Rabbit." The Proceedings of the Society for Experimental Biology & Medicine, Vol. 72, page 718, Oct.-Dec. 1949.

4. Howes, E. L., Meyer, K., Blunt, J. W.: "The Effect of the Hyperadrenal State on the Connective Tissue." The American Journal of Pathology, Vol. xxvi, No. 4, page 709, July 1950.

5. Spain, D. M., Malomut, N., Habit, A. et al.: "The Effect of Cortisone of the Formation of Granulation Tissue in Mice." The American Journal of Pathology, Vol. xxvi, No. 4, page 710, July 1950.

STANDING ORDERS — THE RESPONSIBILITY OF THE INDUSTRIAL PHYSICIAN

JAN LIEBEN, M.D., *Hartford*

The Author. *Industrial Hygiene Physician, Connecticut State Department of Health*

Standing orders represent a preliminary understanding between physician and assisting personnel about routine conduct of a medical service (*J. A. M. A.* 8-23-43, Volume 122, pp. 1247-1249—Standing Orders for Nurses in Industry).

Medical services in industry vary considerably and are dependent to a great deal on the size and nature of the plant providing them. There is only one plant in this State that provides full-time physician's service for all 3 shifts. There are several plants which employ one or more physicians to cover 1 or 2 working shifts. Other plants employ physicians on a part-time basis, which varies from 1 hour per week to 6 hours per day. The great majority of plants, however, are dependent on the services of physicians who are employed on a retainer basis or fee for service basis and come to the plant only when called, or treat patients referred by the plants in their own offices.

We find then that industrial plants have physician's services available but that first aid and emergency medical care in most factories has to be undertaken by persons who are not physicians. These are highly trained industrial nurses, recent nursing graduates, veteran Army or Navy corpsmen, trained attendants, practical nurses, Red Cross First Aiders and persons without any training.

LEGAL ASPECTS

The medical practice act (Statute 442a) expressly forbids anyone to diagnose, treat or operate unless he or she is in the possession of a license to practice the healing arts but exempts emergency procedures from this provision.

The nurse practice act reads:

"SEC. 4423 DEFINITION

"The practice of nursing is defined as follows: (a) The performing, for compensation and under the direction of a licensed physician, of any professional service requiring special education, knowledge and skill in nursing care of those mentally or physically ill and in the prevention of illness; or (b) the performing, for compensation and under the direction of a licensed physician, of any of the simpler procedures required in nursing care of the sick, not involving the specialized education, knowledge and skill specified in subsection (a)."

This act clearly points out that registered nurses and trained attendants can not practice except under the direction of a licensed physician. Trained attendants and registered nurses are licensed under the law. Other First Aid personnel are not mentioned in the statutes.

There has been no case in Connecticut to test the value of written standing orders in a court of law. But from cases in other states, it may be possible that the value of verbal orders is highly questionable and that only signed written standing orders will carry any weight.

PURPOSE OF STANDING ORDERS

In order to enable a nurse to perform first aid treatment for accidents, illnesses, redressings, etc., in accordance with the wishes and views of the physician, who is ultimately responsible—she should have recent signed written standing orders. These standing orders should be periodically reviewed by the plant physician and nurse in order to keep them up to date. New drugs, new procedures, changes in personnel make a 6 month to yearly review desirable.

Trained attendants, first aiders and other personnel may be accused of practicing medicine without a license or sued for damages when dispensing aspirin or applying band-aids repeatedly or when engaging in other simple services of medical care under company auspices. In order to limit their activities to procedures of first aid and emergency treatment, signed written instructions are necessary.

An on-call industrial physician who receives patients from certain plants should write his own individual standing orders; it will establish a better relationship between the physician and the management of the plant and also between the physician and the assisting personnel who channel patients to his office.

Standing orders should be clear, short and concise. They should be tailored for the individual executing them and specific for the hazards of the plant. It is obvious that an experienced industrial nurse will be given much more responsibility than a new graduate. Also, a foundry will need standing orders different from those for a textile plant.

The American Medical Association Council on Industrial Health and various insurance carriers have available printed suggested standing orders for industrial medical departments which will form a useful guide for those about to write standing orders. Copies, and consultation, are available on request from the Bureau of Industrial Hygiene of your State health department.

THE DOCTOR'S OWN MENTAL HEALTH

EVERETT S. RADEMACHER, M.D., *New Haven*

I HAVE often wonder what would happen if one presented a paper to a scientific group, the content of which was unproven statistically, uncomplicated by isotropes, and utterly unadorned by philosophy. The title of this paper presents an opportunity to find out because the subject is both naive and presumptuous. For the doctor is supposed to know everything about health and also is never supposed to be sick. To tell a doctor about his own mental health is presuming in spite of all the inferences made, comparing him and his own to the shoemaker and his shoeless children.

The simplest definition of mental hygiene I know is that used by the late Dr. Harry Stack Sullivan, namely, "Mental health is the ability to live adequately and appropriately together." This simple definition expresses the very crux of the difficulty that most people have in the living of their lives. They have not learned the method of living appropriately together. Even the simplest living arrangement of husband and wife uncomplicated by the triangles created by children, lack or fail an appropriate getting along together. The doctor's own mental health rests primarily on this same tenet. There are some other factors.

Oftimes there is a tendency to set off doctors as a very special group of people. They are regarded as the most self centered of all professional groups, independent, yet humble, willingly sharing, selfless, but ever watchful lest they be coerced. Doctors are a special people but so are wrestlers, hairdressers and bartenders. The fact remains they are human beings and therefore subject to the same environmental influences as the patients they serve.

The doctor, then, is just like everyone else. He wants to be different, but not too different, and at the same time, he wants to be exactly like all the others just as long as he doesn't lose every shred of his personal identity.

Yet, by tradition and throughout history it is expected of him that he be singled out. The Old Testament writing exhorts the people to do him honor. And, it is also written, "The skill of the physician shall lift up his head and in the sight of Great Men he shall be praised." It is a status that we have consciously thought was our due and now it is part of our problem because the modern social trend seems to be reducing us to mere merchants.

The doctor's predicament is also different because of his closeness with catastrophe and the torn emotions of his patients. All day long he must inure himself against the very drama that constitutes his daily work. He sees many people often at their worst. He sees them sick, frightened and awed at his presence, or irascible because of what he asks them to do. He sees them grateful to him for some minimum bit of effort on his part, and resentful of him even though he has given his very heart to try to get them better. There is no other profession in which one becomes so aware of how equally and intensively one can be both liked and hated; praised to the skies by some and foully maligned by others.

At the close of an unmeasured day the doctor goes to his home to be brought closer to his own reality and the jolting of his own personal problems. His children are not always reflecting him gloriously. The Hippocratic oath to which he feels some allegiance does not reconcile itself to the costs of living and the material things that are a part of the standard he is expected to display, to say nothing about the luxury component extras that one's family like to have.

The doctor subjects himself to the same extravagant daydreaming of everyone else. Gradually, he may realize he is watching the disintegration of the castles while his very shoulders still try to brace the crumbling walls.

I can't think of anything more ironical than the psychiatrist who is depressed, yet, I can't think of anything more logical, for in spite of insulin, electric shock treatment, lobotomy or leucotomy, miracles still do not take place in psychiatry. The every day

Presented at the New Haven Medical Association, January 16, 1952

person and his problem looks for the miracle and is disappointed. The psychiatrist must still look at the patient's problem, explain and re-explain, the nature of his emotional hurt and try to help him to understand. The psychiatrist is far too often in the situation of knowing what is wrong but is left impotent because the patient simply wants the problem erased, not corrected.

Seldom is there a willingness to face the task of correcting the difference. The psychiatrist, then, may be called a failure because he has no magic wand. Today with psychiatry headlined in almost every magazine and movie, much more is expected of him so there is more disappointment when the patient finds that he, too, must work to affect a change.

The psychiatrist as a result may become a first class alarmist and go about viewing everything with alarm. I recall the time when I was on the Training Station. We were flooded with cases of eneuresis. There was one man, a man of about 36, a married man who was brought in to me for this trouble. Not entirely from curiosity but with real concern, I asked him what his wife thought about this difficulty. His response was, "Well, you see, sir, she's tetched a little that way herself." While it certainly can be said that life for this couple is no bed of roses, it illustrates the unnecessary alarm of the psychiatrist. We often mess into things we could well let alone. But these are problems involving the psychiatrist's mental health; not yours. There are some similarities, however.

An internist may treat an emotional disorder as if it were organic with some success, but it is certainly wrong for a psychiatrist to treat an organic disorder on the assumption that it is, or may be, emotional. The internist will use something in the way of a symptomatic therapy which may be all that the patient needs. This may be a drug, a suggestion, an explanation or just reassurance. Reassurance in itself however, will not stop a true anxiety state and the physician's feelings may be hurt, especially when he learns that the patient has gone elsewhere for some new reassurance. I think, however, that one of the more unconscious ways in which the practitioner can create more problem is when, as the patient leaves his room, he gives the pat on the shoulder and says, "Take it easy now." You have no idea of the reverberations of this remark.

During the time I was in the Training Stations, I had hundreds of men trying to tell me how unsuited they were for the military through making use of the expression, "Even a long time ago my doctor said I should take things easy." But that is a minor aspect of the effect of this remark. Its effect on a household is terrific.

As an illustration, the following is a common case situation. A man begins to voice vague physical complaints in his home, tired out, headaches, doesn't feel well. At first his wife pays little attention, then becomes a little irritated. She suggests "Why don't you see a doctor?" That is a remark which the man wants to hear but, at the same time, his pride is wounded. He responds, "Who, me? I'm all right." But, he continues to complain. Finally, he consents to see the doctor. At this time of the initial visit he will tend, of course, to try to minimize his complaints to the doctor, and to say that he just thought he had better get a check-up. The doctor finds no organic changes and tells him that he is okay. The man is reassured for has he not said right along, "I'm all right," but as he leaves the doctor's office, the doctor pats his shoulder and says, "Take it easy now." The man returns to his home that evening. His wife, who by now is genuinely alarmed, asks, "What did the doctor say?" Now the patient has the upper hand and he does not want to lose that high degree of concern expressed for him, so he becomes noncommital, tries to show a form of irritation at being questioned, but always ends with the words, "The doctor said I have to take things easy." It is a sword over his wife; in other words, "Don't ask me to do things that I don't want to do such as you have been doing."

His wife is left hurt and bewildered. Is there something wrong? Is he withholding information? Should he be trying to work, and also, what is she supposed to do? Sometimes she calls the doctor and he tells her that her husband is physically well, but if he is physically well why should he take things easy? She is vexed because she has been put to so much unnecessary anxiety. It is human then that she will want to get even with her husband for being put into this state of concern. The alternating patterns of sickness as they seem to take place in the two adults of so many homes, is really nothing more than a way of getting even, one with the other, "You made me worry, now you worry over me." Sickness is not something one enjoys. It is just the lesser of two evils.

No two persons can be dominant in the same realm at the same time for obviously there is immediate friction. By the same token, no two persons can be subservient in the same realm at the same time, else again there is some form of dissension.

For example, let us recall what happens in that simple homely scene which starts with that so completely disarming remark of the wife, "What do you want to do tonight, dear?" In spite of the disarming nature of the remark, the husband is on guard. Also, he decides to be cautious and gracious, and responds, "Oh, I don't know. What would you like to do?" This is exactly the last thing the wife wanted to hear. There is no arguing with it. The response is likely to be, "Don't you ever have an idea of your own?" She has wanted to relinquish the dominance. Maybe last night she made the decision and the movie turned out to be a poor one. She does not want to have two strikes called against her because she would be likely to have it held against her.

A husband would be better off in saying, "I'd like to go to the fight," even though he knows that his wife disapproves of such uncultured form of activity. It doesn't mean that he would go to the fights, but at least he has expressed a choice.

Yet the need for dominance, ascendency and subserviency and the relinquishing of responsibility, are constantly alternating needs because of the difficulties each has encountered in his routine day. With the two adults taking each other for granted there cannot help but be built up an awareness of how much effort one has had to use and a very martyred attitude. In fact, one might almost say that in these days, "not to be martyred is in itself a martyrdom."

The role of the doctor's wife can be an inglorious one, for she, perhaps more than any other wife, may be left playing second fiddle to the doctor's practice. It is not necessarily a jealousy created in her but just the emptiness of being left out. When she attends some little social function, she is exposed to such remarks as, "Oh, he was so nice to me when I was upset. He is so wonderful." She may think, "Oh, yeah! He can't even fix a lampshade," and, "if he can be so nice to others, why can't he be nice to me."

The doctor has to be liked in order to get along. His ministering to others is his livelihood and his family's security. The more in demand he becomes, however, the more his wife may feel left out or stranded. Her plight may be viewed by her as one that is far removed from earlier pleasant phantasies of being the wife of a physician. The phantasy envisioned status, relative ease, no medical problems, importance, a sort of glorified receptionist. Instead she pictures herself a tired, bedraggled housewife harried by the difficulties of the children.

Sometimes the doctor has succeeded in winning some degree of recognition. The beneficient beam of recognition can burn one to a third degree of bitterness especially if it is recognition without recompense. With recognition unaccompanied by recompense the home situation can be made more explosive because the immediate burden has not been made easier. A doctor's wife wants and expects him to be important, but she doesn't want to be left out.

One of the most frequent expressions which everyone gives vent to when the going is rough is, "Oh, I wish I were dead." One does not mean dead in the sense of being gone, departed and buried, just merely, "I wish I were relieved of these burdens and be understood." The philosopher Kirkegaard, who more recently has came into so much publicity, expressed this idea in this way, "When death is the greatest danger, one hopes for life. Yet, when one is confronted with an even greater danger, one hopes for death. When death becomes one's hope, despair is the disconsolateness of not being able to die."

The state of despair is the disrupting factor of so many homes today. The despairing attitude culminates in the anxiety panic states so frequent among all of our medical entities.

Anxiety is an emotion which makes the most trivial assume the same significance as the most important. When everything assumes extreme significance it is easy to understand why a person is beside himself.

The fear of falling short, of not living up to one's ideal, the fear of a failure, the fear of being hurt or disappointed again, makes one wary and watchful of every bit of effort, every task, and even one's own thoughts. Whatever is noticed is noticed with alarm. It is not so much the conflicts we have that make one anxious, rather the misinterpretation of our conflict. The technical task of helping an anxiousness rests with the untangling of these misinterpretations. Through this can be developed the greater responsiveness each to the other; the thing that each

marriage partner is most in need of, for no one likes to be taken for granted.

The problems of the home increase by a mathematical progression with the addition of one or two children. Prior to having children there were all kinds of unusual resolutions which parents make about what they will do for their offspring. They will buy them things of course, but primarily they will be pals to them and understand them. We hope to save them from every hurt. Yet, at the same time that we were making these resolves, we also dreamed of how our children would satisfy our every whim and become all the things we are not.

Later on, one finds that trying to play with a toddler tot leads to boredom after the first five minutes. One learns, too, that the children can whine and complain and leave one so dismayed. One finds that children really do not want us as pals. We interfere with their uninhibited fervor. They do not always shine in school. They are not always interested in the activities we hoped they would be and very few of them become captains of football teams.

Now of course one can always say that these unfortunate traits or failures come from the other side of the house. The most popular idea of heredity, "that all, if any, of the good traits of our children come from our side of the house and vice versa."

A doctor's wife may be bothered by the children's problems, too. She may feel the weight of the irritations and in her own uncertainty blame the doctor for not having interest in the children, always is too busy, not like other children's fathers.

As in all family life the need to emphasize the use of the individual interests of husband and wife is also in the doctor's home. The individual interest must be accorded respect by the other; not ridiculed, scorned, or begrudged. The interests which the adults may have in common are good but the individual interest when it is respected by the other is the element which helps a feeling of freedom. It is one of the solutions for any happy home. In other words, produce that great "Oneness"—and there is no question of which one.

When such individual interests are lacking a husband may be held to blame for children's problems, their school difficulties and troubles in getting along with their friends. A doctor's wife may think he should know how to avoid these troubles just by virtue of his medical education.

A commonly sought way to avoid any possible hurts or disappointments is to assume indifference. Indifference is an emotion or rather a lack of emotion which holds down enthusiasm, tosses aside griefs, and keeps one unmoved by any circumstances. Indifference is beautifully protective but is not satisfying. Therefore there is still restlessness within. Indifference is the thing that helps to make those long periods of sullen self-conscious silence of the home. There is nothing more disconcerting. One wants something in the way of change, yet dreads the very thought of suggesting it.

The fear that we may lose out or the fear that we may have to give up something becomes obsessive. This actually reaches such extreme that we even worry about giving up something of a nature that actually we never had.

Our particular era has seen much more usage of the protective indifference. We have become somewhat distrustful of our own emotions. We have tended to regard such things as evidence of weakness which we must keep hidden at all costs. Or, if we should show some emotion or some enthusiasm we might be considered naive. So, we try to keep hidden much of what we really would like to express, especially in the confines of our own homes. We hurt ourselves by this silence. Then there is still another factor involving the doctor's own mental health and that is the peculiar paradox in the very nature of our competition. It is an unusual thing for there is that intellectual appreciation of our common educational background.

There is involved here, though, all the differences in fees for services, the differences of individual earning capacity, especially as it is further altered by specialization. There is that awareness of what seems to be the greater ease of living of someone else. There is always that patient who for years we have carried along for next to nothing who because of some whim consults elsewhere and, of course, pays more for a single visit than we have received in a year.

There are those irritations which arise from lay committees on medical economics who question whether we are in business to help people or to make a living. There is the struggle over a federalized system of centrally administered medicine about which we still have to defend ourselves.

We know that our patients shop around and we try to remain calm about the hurt, but it still can

set off a defensiveness. Yet, even with knowing these things, misunderstandings still take place. Misunderstandings between us become further inflamed by our patient's comments. Sometimes these comments are alleged statements we are supposed to have made. Sometimes they are actual quotes that we have made but have been taken out of their original context and therefore are given an entirely false impression. These things put the doctor on the defensive regardless of the degree of eminence he has attained.

I recall a case of quite a number of years ago in which the patient had at least four doctors practically throwing rocks at each other because she spread stories to the effect that each of these doctors had charged her for removing her appendix and it was only in her last operation that this was done because she saw it. It never occurred to the doctors involved that this person was known by many people for her erratic conduct and that therefore her comments were unreliable. Yet, there was the fear of having been put in a bad light which charged the medical atmosphere with undue emotion. The situation was helped materially by a committment. The incident is one perhaps unprecedented in medicine for it marks an occasion where the psychiatrist pulled the surgeon through.

What can be done to improve the Doctor's Mental Health? Foremost, the relationship in the home, the effort toward a greater responsiveness, verbally and with constancy. There is no question but what a rekindling of the thing called love has in it so much in the way of a transcendance of oneself that helps him to more nearly live up to his ideal of what he wants to be.

I am not implying here a much older and misunderstood Freudian theory of sex as being responsible for the neurotic symptoms of our time. Love is more comprehensive. Furthermore there are other needs than sex, and, contrary to the ideas of some people, sex is not accountable for all the peculiarities of human behavior. Love transcends the luxury quotient. It is the essence of a state of mental well being.

With the security of love, the doctor can use his cleverness in the competition of life with humility and respect, and with less consciousness of how much effort he has used compared to someone else. He will enjoy himself without being afraid of himself because he does so. He will have Mental Health.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Fairfield, Wednesday, October 1

Wee Burn Country Club, Darien

Golf: 1:00 p. m. Business meeting: 4:30 p. m.

Dinner: 6:30 p. m.

Speaker: John M. Gleason, Chief of Police of Greenwich

Subject: RECENT EXPERIENCES IN POLICE MISSION IN GERMANY

New London, Thursday, October 2

Place and speaker to be announced

Litchfield, Tuesday, October 7

Torrington Country Club, Goshen

Time of meeting and speaker to be announced

Middlesex, Thursday, October 9

Place and speaker to be announced

Windham, Thursday, October 16

Place and speaker to be announced

Tolland, Tuesday, October 21

Place and speaker to be announced

New Haven, Thursday, October 23

Place and speaker to be announced

Hartford, Tuesday, October 28

Chippanee Country Club, Bristol

Golf: 12:00 p. m. Business meeting: 4:30 p. m.

Social hour: 6:30 p. m. Dinner 7:00 p. m.

Speaker and subject to be announced

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Post Doctorate Education

A commission appointed by Governor Dever of Massachusetts has recommended the establishment of a medical school under the auspices of the University of Massachusetts to be established in Boston. This is aimed to relieve an alleged shortage of physicians in Massachusetts. *The New England Journal of Medicine* points out editorially that not only has Massachusetts a higher physician-to-population ratio than almost any state in the union, but, because of this and the low per capita income of physicians in New England, an increase in medical graduates within the State would be reflected in an increase export of doctors to other states.

An interesting alternative to a new medical school is suggested, which is the establishment of a new and different type of graduate school of medicine. The primary purpose of such a school would be the improvement and expansion of intern and residency training by subsidizing the cost of such educational programs. This would enable hospitals other than the present teaching hospitals to develop programs which would be attractive to recent graduates in medicine. It would also aid in relieving the shortage of interns. Many hospitals are fully suited to the development of such programs but are unable to do so because of lack of funds.

The alternative plan is more than an interesting suggestion, for efforts along this line have already been successful in several places in this country, not, however, under state subsidy.

Within the past three years we have had a similar development in Connecticut under the auspices of the Yale School of Medicine when such a plan was inaugurated under the able leadership of Dr. William R. Willard. The interest of the Connecticut State Medical Society in this and other phases of post doctorate education was made manifest by a generous donation to Yale at the beginning of the program. Medical schools and teaching hospitals are in an opportune position to widen their important influence by increased interest in post doctorate education. A number of non teaching hospitals within our state have shown interest in the possibility of participation in such training programs. In some instances it has been only because of lack of funds that further progress has not been made.

The suggestion from Massachusetts to use state funds is not only interesting but timely. In Connecticut as in Massachusetts it can be debated whether we need an increase over the present inflow of doctors. We can, however, profit by better trained ones.

Surgical and Medical Expense Protection — Some Figures

The number of people in the United States covered by surgical expense protection is second only to the total of persons protected against the cost of hospital care. At the end of 1951 there were 65,535,000 people with surgical expense protection, a 20 per cent increase over 1950. Most of these people are covered either by Blue Shield or insurance companies.

The growth of medical expense protection has been rapid in recent years although this type is latest in the field to be actively developed. At the

end of 1951, 27,723,000 persons were so protected, an increase of 28 per cent over the year previous.

During 1951 the insurance companies continued their leadership in covering people against surgical care. Group insurance and individual insurance policies accounted for 42,771,000 persons. Blue Shield and medical society plans afforded protection to 24,095,000 persons. Other agencies covered 2,790,000 people. The total for surgical expense protection was 63,535,000 after allowing for duplication of coverage.

In the area of medical expense coverage, Blue Shield and medical society plans remained the leaders, providing protection to 14,347,000 persons. Insurance companies covered 12,176,000 people and independent plans 2,791,000. After elimination of duplication, the number of people covered against medical expense at the end of 1951 was 24,723,000.

Figures for the New England area at the end of 1951 show surgical expense protection, 4,676,000; medical, 2,525,000 persons.

In considering an over-all view of sickness expense protection for our people we must not forget additional types of protection such as Blue Cross, state sickness plans, and government employee plans. Other types of protection which provide millions of dollars in benefits to the injured and disabled include: Workmen's Compensation; disability benefits in life insurance policies; commercial accident policies; complete medical care for persons in the armed forces, persons in public institutions, and war veterans under certain conditions; protection under automobile, residence and other types of liability policies.

A broad view of protective measures must also consider voluntary protection against loss of income due to disability. At the end of 1951 almost two-thirds of the nation's 61,000,000 employed civilians were thus protected.

From the above figures it is plain that we are an insurance minded people and the dramatic expansion in voluntary health coverage as shown by the 1951 statistics reflects the desire of the American people to help themselves, wherever possible, in meeting the costs of accident and sickness through methods of their own choice.

Citizens and Doctors

Doctors are citizens first and doctors afterward. In a dual role, they have a debt to the many individuals, community groups and national organizations that have allied themselves to keep their profession free from political domination. For that reason the interest of the doctor in politics must be active and not passive. He must be an informed citizen as well as an informed doctor. He must not forget that the social planners have a firm belief in the federal control of medicine as the all important first step in their scheme of socialization. To them liberty means the relieving, by the state, of the individual of responsibility. They forget that the founders of our republic sought to limit the powers of government, that Thomas Jefferson, in his inaugural address said, "Restrain men from injuring one another, but leave them otherwise free to follow their own pursuits of industry and employment."

It is only by knowing the full history of the progress of socialism in Great Britain and in this country that the doctor can become best informed as to the importance of freedom in medical practice. An informed doctor is helped not only in his own thinking, but is able to help others who look to him for guidance in these questions. The doctor must be concerned with politics if he is to be a good citizen and a good doctor. "Eternal vigilance is the price of liberty," is a saying attributed to the Irish Statesman, John Philpot Curran. His true words, however, have deeper significance. In a speech upon the Right of Election (1790) he said, "It is the common fate of the indolent to see their rights become a prey to the active. The condition upon which God hath given liberty to man is eternal vigilance; which condition, if he break, servitude is at once the consequence of his crime and the punishment of his guilt."

Dr. William T. Salter

The JOURNAL expresses its deep sense of loss in the death of Dr. William T. Salter, a valued member of The Connecticut State Medical Society and a member of the faculty of the Yale School of Medicine. As a scientist and a teacher Dr. Salter's contributions to medicine were of highest order. Great as they are acknowledged to be, however, they were parallelled by his contribution to the combined interests of medicine and pharmacy outside of academic halls. His capacity for friendship reached far and wide among the members of these professions. No one within our State did more to advance their mutual understanding. His contributions to this JOURNAL in the fields of medical science and medical

history revealed his great scholarship. His devotion to the ideals of medicine and his fortitude in his own health problem remain as an inspiration to those who were privileged to be his friends.

Our Clinical Congress

Our Clinical Congress is one of two major enterprises of the Connecticut State Medical Society designed to bring to its members the latest developments in the field of clinical medicine. Those responsible for the program and arrangements give extended thought over preceding months to the needs and desires of the practicing doctors of our State. To this loyal group of workers and to those of the State Society Office should be added the large number of our members who contribute to the success of the Congress by taking part in the program as chairmen and discussants. For its financial support the Congress depends upon registration fees which always have been kept at the minimum necessary for operation. In this way it differs from the Annual Meeting which receives rentals from its commercial exhibit, a feature which is not feasible for the Congress. It is thus a part of good medical citizenship for members of our Society to register for the Congress and give tangible evidence of their interest and support. We can all be proud of its record of accomplishment. At the time of its beginning twenty-eight years ago it was essentially another Connecticut First for it was a pioneer in this type of medical society endeavor.

The Congress has gone steadily on in its original purpose as being interested primarily in the practical aspects of medicine. The program this year eminently carries out this concept. The subjects are timely and suitably varied and the speakers represent the best in American Medicine. Your early registration is helpful in many ways, including a considerable convenience to yourself.

Colonel Comfort Infirmary

The Colonel Charles W. Comfort Jr. Infirmary was dedicated at Camp Lodge, Niantic on July 12, 1952 as a feature of Governor's Day ceremonies. A plaque identifying the infirmary was unveiled by Colonel William B. Smith of Hartford, state surgeon general.

In his address Lt. Gov. Allen said: "We signalize in this ceremony not only Colonel Comfort's extraordinary record and skill and bravery, but also those other virtues which he exemplified—his unfailing compassion, his exemplary modesty and the unswerving integrity which marked his long career as an officer and a gentleman."

Colonel Comfort has had a long career as a medical officer. He joined the Connecticut National Guard nearly 40 years ago. He served on the Mexican border in 1916 and then in France during World War I. His "sustained heroic performance" at the Battle of Siecheprey, a battle famous in Connecticut's military annals, won him the Distinguished Service Cross.

After the First World War he served as state surgeon, State Staff; colonel of the 118th Medical Regiment, division surgeon of the 43rd Division and surgeon general of the State of Connecticut.

Tribute to Dr. Francis G. Blake

The June 1952 issue of *The Yale Journal of Biology and Medicine* is entitled The Francis Gilman Blake Number. It bears fitting tribute to the late Sterling Professor of Medicine at Yale who died in January this year from coronary disease, with a reproduction of the portrait in the Yale University Art Gallery, a biographical sketch by John R. Paul, and the text of the addresses delivered at the memorial exercises held at Yale on June 15, 1952.

Observations On Use of Gamma Globulin

Whether gamma globulin will be effective in the prevention of paralytic poliomyelitis is not now known. On the basis of animal experiments and preliminary study on humans, it is possible that globulin will have value in human poliomyelitis, but serious questions remain to be answered before such a hope can be substantiated. Nevertheless, public dissemination of information on the status and objectives of current studies, incompletely presented or misunderstood, has created a serious demand for gamma globulin which cannot be met.

Virtually the entire output at current production rates is required to meet the demand for prevention or modification of the course of measles and infectious hepatitis.

Under the circumstances it is obvious that the existing limited supply and current production of gamma globulin should be reserved for use in these diseases in which its efficacy has been established.

The Hospital of the Future

Excerpts from address by Dr. Jack Masur, Chief, Bureau of Medical Services, U. S. Public Health Service, Washington, D. C., at 50th Anniversary Convention, American Surgical Trade Association, Chicago, Illinois, June 5, 1952.

By the turn of the next century, I think we will see many more of our hospitals built outside congested city areas. They'll be supplemented by major clinics within the city set up to provide facilities for diagnosis and treatment for ambulatory patients. Most hospitals will be single story buildings made largely of shatter-proof plastic and light-weight alloys. Each room will be single. The ward will be on its way to join the dodo in extinction. All rooms will be arranged along one side of moving corridors. They will have separate outside doors leading to patios and gardens. All will have private baths. Additional plumbing facilities will be built into electrically operated beds. Indirect, fluorescent lighting available in a variety of colors will change the color of the walls to suit the mood of the patient. There will be built-in television. Windows, where desired merely for the psychological effect, will have shatterless, self-cleaning, one-way view plastic panes which permit the transmission of ultra-violet sun rays. There will be twice as much laboratory space as bed space. The entire building will be completely air-conditioned with wide range of climatic control. Heat and light will very likely be provided by atomic or solar energy.

Food service in the hospital of the year 2000 will no longer be a source of gags for comedians. Meals will be metabolically balanced; they will contain chemical nutrients, vitamins and hormones prescribed for specific disease conditions and—equally important—they will taste delightful. They will be cooked by radar with added taste factors that will please even the most finicky appetite. Dishes and trays will be disposable, eliminating the need for dish-washing equipment.

The communication system will provide instantaneous contact with doctors anywhere in the hospital by wrist watch radio. And departmental staff meetings will be held over a television network that extends to the branch clinics of the main hospital.

Blood banks, blood-vessel banks, cornea banks, and bone banks, all give us a glimpse of what we are approaching in reconstructive surgery—or perhaps even organ replacement surgery.

In our larger hospitals, Van de Graaff generators, betatrons, and synchrotrons will be standard multi-million volt equipment for the treatment of cancer—if indeed we do not develop a chemical or hormonal approach to this great killer. X-ray equipment will be a fraction of the size it is today, and will be done at the bedside of the patient. Diagnostic fluoroscopy will be in three dimensional technicolor. And radio-isotopes—which as a new device in diagnostic perception has been hailed as the greatest discovery since the microscope in the 17th century—will have sensitive selectivity for the diagnosis and treatment of a wide variety of ailments.

But important as the developments in medical science and architecture may be to patients, physicians and nurses alike, there are other trends in the wind which I believe will make greater changes in our hospitals. The first concerns hospital beds.

Of course we all recognize the need for an adequate number of beds. And we recognize the critical shortage that exists. But the construction of hospitals is not in itself the solution to our health and medical problems.

We still need a considerable amount of hospital construction to meet basic requirements. We must maintain a continuing program for the construction of general hospitals, medical centers, and especially facilities for mental illness, tuberculosis and chronic disease. But each new facility must be more closely integrated with those now in operation and with other contiguous health and medical services.

In developing the hospital survey and construction program, for example, we have placed far more emphasis upon the establishment of a strong network of hospitals with everyone, providing a high standard of service with full use of all the health resources in each community and the surrounding area. There are several excellent examples of integrated hospital systems in the country now. And others are developing. This trend will have a profound effect upon the quality of the medical care provided by the hospital of the future.

The second important trend—and one that's already affecting our hospitals—is the practice of "early ambulation." We have learned that a man gets well faster and more completely after an operation if he gets out of bed as soon as possible. We used to think that it was imperative for a post-operative patient to lie flat on his back for at least a week or

ten days. Now many patients are up the first day, totter to the bathroom on the second day and are out on the sun deck the next morning.

The third important trend which is changing our hospitals we call rehabilitation.

We are approaching sound solutions to the problem of what a hospital can do with "Those who are not yet fit for a work-a-day life."

More and more, the physician will consider the patient as a person, not as a disease. As the great Boston clinician, Dr. Shattuck, once said, "It is more important to know what kind of a man has the disease than to know what kind of a disease the man has."

Before the ASTA celebrates its One Hundredth Anniversary after the turn of the next century, a patient will no longer be discharged as "cured" merely because his fever is down or the stitches out. The doctor will have learned about his family, his job, his attitude toward returning home and to work, or his feeling about learning a new way of making a living. The patient will have help with the readjustment he must make. And his family will know how they can help in the problems that lie ahead. We will not say that a patient is "discharged cured." Instead, we will say, "Discharged ready for return to his old job," or "discharged ready for work on his new job," a job for which the hospital helped him prepare himself.

The fourth trend which will change our hospitals of the future hardly deserves designation as a trend. But it will come much sooner than the year 2000. It must come this year, next year, as quickly as possible. Otherwise—as some gloomy prophets have warned—rapidly climbing costs of medical care may price the hospital out of business.

Something must be done to keep down the cost of medical care to the patient. And it seems to me that one of the most practical approaches to this problem is to keep more patients vertical instead of horizontal. We know that many cases can be diagnosed and treated while the patient is still on his feet. It isn't always essential to hustle a patient into a hospital bed before diagnosis and treatment can be started. Ambulatory diagnosis and treatment are faster, cheaper and more convenient to the patient. We can provide such service with some reorganization of existing facilities and personnel. Future hospitals, as I have said before, can set up branches designed especially for the treatment of ambulatory patients. And I think we will see a definite trend in this direction within a few years.

If public interest in health continues to increase as it has during the past few decades, I think all of us will become more concerned with what we now call "preventive medicine," which will certainly cost the average patient less than curative medical care.

In the past, there was a clear distinction between preventive medicine and curative medicine. Preventive medicine was carried on by public health agencies, dealing with things as a part of environmental sanitation—organisms, insect vectors, water, sewage. Today we are finding it increasingly difficult to make a clear distinction between prevention and treatment as it applies to us as individuals. A major portion of the medical practice of the future will be preventive. But it will not be limited to the former concept of public health.

With the increase of the degenerative diseases, more attention is being given to the problems of early detection and retardation. Each case presents an individual diagnostic and therapeutic problem. The etiology of such disorders as arteriosclerosis, hypertension and diabetes mellitus consists of many factors, differing in each case.

I think the changes in our hospitals over the next half century will be far greater than any in the past 50 years. Improvements in structure and design to provide more comfort for the patient and more efficient use of the skills of physicians, nurses and other personnel are sure to come. Advances in curative medicine will very likely astound us. But, as I have said, I think we will see even more revolutionary changes in the hospital of the future because of the four trends I have outlined.

THE PRESIDENT'S PAGE

Public relations, incorrectly used as the current term for the activities of a press agent, is with us in all its phases. Improved and newer modes of communication have made us an omniscient people. A public poll on questions as diverse as, "Shall We Legalize Mercy Killings?", or, "Shall We Invade Manchuria?", show only 4 per cent to 6 per cent of those interviewed as having not formed an opinion. As a people we are fully informed on all topics. Those who direct medical publicity will utilize the newer modes of communications to bring to the people a true picture of the progress that is being made by organized medicine to make available the benefits of modern medicine to all the people.

The stand taken by organized medicine as it is related to certain social reforms has been challenged by some statesmen and political leaders. It would be a tragedy if the American people, by adverse publicity, were brought to believe that doctors or their organized groups, were obstructing progress as to providing medical care to all the people at a cost that is within their financial means. Doctors as individuals are eager to promote social reforms and it would be a mistake for organized medicine to allow itself to be maneuvered into the position of seeming to be against such progress.

We are at the peak of an election campaign to choose a President and complete a Congress. Doctors as individuals and as part of organized medicine are profoundly interested in this campaign. Party labels have become meaningless in the United States and so it is a fitting time for all of us to rearrange our prejudices. As citizens, we are concerned with the growth of power in our government. What all of us fear is the Absolute State. The founders of our Republic feared this and designed our system of government to check the growth of such power. It is against this threat that present medical publicity is directed. The people resent being directed how to vote. They welcome information that will aid them to intelligently estimate policies as well as personalities. If the truth about organized medicine is told, the American people can be trusted to keep faith with their doctors.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

A special meeting of the Council was held at the offices of the Society on August 6, 1952. The meeting was called to order by the Chairman, Dr. Howard, at 5:30 P. M. There were present: Drs. Archambault, Couch, Danaher, Gallivan, Gens, Gibson, Gildersleeve, Howard, Murdock, Phillips, Root, Thoms, Tracy, Whalen, Barker. Absent: Drs. Buckley, Feeney, Fincke, Flaherty, Gettings, Labensky, Russell, Shepard, Ursone, Walker, Weld.

1. The purpose of this meeting was to hear the report of the special committee of the Council that had been appointed to inquire into the advisability of adding to the Society's building to provide space for the state office of Connecticut Medical Service. The committee consists of Drs. Creighton Barker, Thomas J. Danaher, Cole B. Gibson.

After explanation and discussion by many it was unanimously voted to accept the report and adopt the recommendations of the committee as follows:

> "Your committee recommends that this Council express itself on behalf of the Society, of a willingness to cooperate in every mutually satisfactory way with Connecticut Medical Service in providing a permanent home office for that corporation and that this action be transmitted to the President and the Board of Directors of Connecticut Medical Service.
>
> "Your committee further recommends that the committee be continued and work in liaison with the building committee which has been appointed by the Board of Directors of Connecticut Medical Service and at an appropriate time, the committee return to this Council with definite recommendations for consideration and if approved by the Council, to present that recommendation to a special meeting of the House of Delegates of the Society."

2. It was voted that Dr. Cole B. Gibson be nominated to be director of the Connecticut Tuberculosis Association for a period of two years.

3. It was voted that Dr. David Cohen of Meriden and Dr. Brae Rafferty of Willimantic be named as members of the Conference Committee with the Connecticut State Dental Association.

Notice to AMA Delinquents

Many physicians in the state have recently received notice from the Chicago office of the American Medical Association that they are delinquent in payment of AMA dues for the years 1951 and 1952 and if they wish to pay dues for 1951 and be reinstated in membership in the Association, they should make payment to the secretary of their county association. This has caused a great deal of confusion in Connecticut. The notices of delinquency were sent from the Chicago office without consulting the office of the State Medical Society. The standard practice throughout the country is for AMA dues to be collected by county associations and it is possible that Connecticut is the only state where these dues are collected by the state office. That is the reason why delinquent members were

requested by the AMA to make payment to county secretaries.

If there are members of the Connecticut State Medical Society who wish to be reinstated in membership in the AMA by payment of back dues for 1951 of $25 and current dues for 1952 of $25, a total of $50, checks for that amount should be drawn to the AMA and mailed to the Connecticut State Medical Society, 160 St. Ronan Street, New Haven, where they can be properly accounted for.

AMA Dues Payment

As of August 1 the record of AMA dues payments was:

Total members in Society	2,744
Officially exempt	208
Liable for AMA dues	2,536
Paid to August 1	2,015
Delinquent August 1	521

1953 Annual Meeting

The 1953 Annual Meeting will be held in the Hamden High School, located on the Cross Parkway, on April 27, 28 and 29. The House of Delegates will meet on Monday, the 27th and the scientific sessions will be held on the 28th and 29th. This is a departure from the usual Tuesday, Wednesday and Thursday meeting, but it is made necessary because of previous plans for the use of the school building. The Program Committee for the meeting is Stevens J. Martin, Hartford, Chairman; John F. Nolan, Bridgeport, and Samuel D. Kushlan, New Haven. The New Haven County Committee on Local Arrangements is A. Lewis Shure, New Haven, Connecticut; John H. Bumstead, New Haven; Robert M. Lowman, New Haven; James A. Gettings, New Haven; Samuel Spinner, New Haven. Dr. Bumstead will serve as liaison between the secretary's office and the Local Committee.

Local Respirator Care Unit

The Society's Committee under the chairmanship of Oliver L. Stringfield, Stamford, serving with George G. Fox, Meriden; Wilson F. Smith, Hartford; and F. Erwin Tracy, Middletown, has met and negotiations for the development of a Poliomyelitis Local Respiratory Care Unit are under way. Local units are in operation in Baltimore, Harrisburg, Richmond and other cities throughout the country. Such a unit in Connecticut would be of the utmost value. The setting up of these units is guided by the Medical Department of the National Foundation. Personnel of the Local Units are trained at Regional Respirator Centers and members of the Center's staff are available for special consultation. The primary responsibility of the Local Units is the care of acute patients and weaning of patients from respiratory aids and their preparation for care at home. Selected patients from the Local Unit can be admitted to Regional Respiratory Centers for short-termed study and evaluation with the understanding that upon completion of the short-termed period they can be returned to the Local Care Unit for further care. Dr. Stringfield's Committee is now engaged in a survey to determine the most suitable location for the Connecticut Local Care Unit.

Meetings Held in August

August 6—Council Meeting

August 15—Committee to Establish Local Respirator Treatment Unit

August 20—Governor's Special Committee on State Institutional Planning

August 27—Public Health Committee Sub-Committee on School Health

August 28—State Conference on Eligibility and Recruitment of Interns

Fifteen Missing

There have been 114 presidents of this Society since its founding in 1792. The search for pictures of these distinguished gentlemen has been rewarding and portraits of all but 15 of them have been obtained. The list of the missing ones is given below and it will be greatly appreciated if members of the Society will use their ingenuity and make inquiry of every reliable source so that pictures of them all may be obtained.

1792 Leverett Hubbard, New Haven
1801 James Potter, Sherman
1803 Thomas Mosley, East Haddam
1804 Jeremiah West, Tolland
1832 William Buel, Litchfield
1834 Thomas Minor, Middletown
1843 Luther Ticknor, Salisbury
1853 Richard Warner, Cromwell
1865 Nathan B. Ives, New Haven
1867 Charles Woodward, Middletown
1873 Ira Hutchinson, Cromwell
1878 Charles M. Carleton, Norwich
1883 Elisha B. Nye, Middletown
1885 Elijah C. Kinney, Norwich
1893 Francis D. Edgerton, Middletown
1905 Edward H. Welch, West Winsted

THE HISTORIAN'S NOTE BOOK

JOSEPH ADDISON ON THE PREVENTION OF DISEASE

GEORGE BLUMER, *San Marino, California*

WHEN the name Addison is mentioned before a group of physicians it usually brings to mind Thomas Addison, disease of the adrenals, and the first adequate description of pernicious anemia, sometimes called Addisonian anemia. But there was another Addison, Joseph, who, with his bosom friend, Richard Steele, published in the *Spectator* his varied observations on men and events in his time, the early years of the eighteenth century. This was almost a hundred years before Thomas Addison flourished.

There are a lot of interesting comments on the "physick" and physicians of the period in Addison's essays and they reveal, just as so many old commentaries do, those curious cycles which occur in medical thought and practice and often result in the revival in modern dress of ancient and half-forgotten medical ideas. It seems worth while to discuss some of Joseph Addison's views on certain aspects of medicine, for he was a widely educated and traveled man, an acute observer, a clear thinker, and richly endowed with that uncommon quality known as common sense. It is well to remember that during his manhood many of his contemporaries overindulged in both food and alcoholic drinks. It was indeed a period of gargantuan feasting, and corpulence and gout were common disorders. As Addison says: "For my part, when I behold a fashionable table set out in all its magnificence, I fancy that I see Gouts and Dropsies, Fevers and Lethargies, with other innumerable Distempers lying in Ambuscade among the Dishes." This after he had described a meal as consisting of "Fowl, Fish and Flesh . . .; Oyl and Vinegar, Wines and Spices, . . . Sallads of twenty different Herbs, Sauces of an hundred Ingredients, Confections and Fruits of numberless Sweets and Flavours." It is quite clear that Addison opines that many of the ills to which the flesh is heir are due to overeating and lack of exercise for his two suggested preventives of disease are (1) exercise and (2) temperance.

As to exercise he suggests various techniques—horseback riding, he says, conduces to health, and he reports that Sydenham, the English Hippocrates, was lavish in its praises. He refers to a book, Medicina Gymnastica, written in 1704 by Francis Fuller the Younger. He also details his own means of exercise. As a young man he used a method which he describes as "shadow fighting" which he learned from the famous illustrated treatise on exercise of Hieronymus Mercurialis. He describes it as brandishing two stakes, one grasped in each hand, each loaded with plugs of lead at the end. This he says opens the chest, exercises the lungs, and gives the man all the pleasure of boxing without the blows. When older he exercised with a dumbell (metallic not human) an hour every morning. He emphasizes that as he is a compound of body and soul he employs labor and exercise as one of the businesses of the day and study and contemplation as another. His physiological (sic) reflections on the necessity for exercise are to us curious. He says that there must be frequent motions and agitations of the body to mix, digest, and separate the juices contained in it, as well as to clear and cleanse that infinitude of pipes and strainers of which it is composed. Labor and exercise, he says, ferments the humours, casts them into their proper channels, throws off redundancies, and helps nature in those secret distributions without which the body cannot subsist in its vigor, nor the soul act with cheerfulness. The effects of this act on the faculties of the mind by keeping understanding clear, imagination untroubled, and refining those spirits that are necessary for the proper exertions of our intellectual faculties, during the present laws of union between soul and body. It is to this particular that we must ascribe the spleen so frequent in men of studious and sedentary tempers and the vapours of the opposite sex. "Providence furnishes Materials but expects that we should work them up ourselves." It is to be noted in the preceding summary that "spleen" is used in the old sense of bad temper, spite,

anger, and that "the vapours," usually referred to as occurring in women only, meant depression or the blues.

In his remarks on temperance, which Addison uses in the proper meaning of the word, i.e., moderation, he states that it has the advantage that it can be practised by all ranks and conditions at any season and in any place. "It is," he says, "a kind of a regimen into which every man may put himself without interruption to business, expense of money, or loss of time." "If exercise throws off all superfluities, temperance prevents them." Physick, he remarks, is nothing else but the substitute of exercise and temperance. He refers to the necessity for medicine in acute illnesses which cannot await the slow operations of his "two Great Instruments of Health." "The apothecary is perpetually employed in countermining the cook and the vintner."

Here then we have an eighteenth century layman who unerringly puts his finger on the ill effects, so far as health is concerned, of some of the social customs of his day. No doubt others before him have performed similar services, but it is interesting to record, especially in view of the modern emphasis on diet and of modern psychosomatic medicine, the far sighted views, expressed in such picturesque language, of one who lived a couple of centuries ago.

LETTERS TO THE EDITOR

To the Editor:

In the *British Medical Journal*, June 21, 1952, Supplement, page 319, is a summary of the recently published hospital costs in Britain. Those who have to deal with hospital costs, and there are many of our readers who do, will be interested in referring to the original published by H. M. Stationary Office, price 10 shillings, under the title, National Health Service Hospital Accounting Returns, year ending March 31, '51.

This report covers the returns from 2,750 hospitals. Only non-teaching hospitals are included and the report includes net cost after allowing for outpatient expenditure.

It is obviously improper to draw close comparisons with our hospitals, for many of the basic factors entering into this huge compilation are different, and the methods of accounting are probably different. Nevertheless, it is fair to assume that there is significance in the comparison as between the various types of hospital service. No such volume of figures has been presented, based on a serious effort to make the collation statistically significant. The Nuffield Foundation has contributed to this study, a fact that indicates the quality of thought that has been expended on it.

The average costs of hospital patients in 2,750 British Hospitals under the National Health Service for the year ending March 31, 1951 were:

COSTS PER WEEK	£	S	P
Wholly general hospitals	13	10	3
Mental hospitals	3	15	11
Chronic hospitals (more than 50 per cent)	6	15	4
Tuberculosis hospitals	8	17	2
Maternity hospitals	16	9	5

It is to be borne in mind that the entire staffs of these hospitals are on salary. This cost is included in hospital costs in this country only in the case of mental, tuberculosis, veteran and some other hospitals although there is a tendency to include salaried medical personnel in general hospitals. Such factors make comparisons dangerous, but these reports will make interesting reading as the years go by. One can also speculate as to the relation of costs to quality of service, a factor that does not lend itself to statistical evaluation.

James R. Miller, M.D.

Appreciation

American Cancer Society, Inc.
47 Beaver Street, New York 4, N. Y.

July 17, 1952

To the Editor:

I am happy to express to you the appreciation of the American Cancer Society for your splendid cooperation with our 1952 Cancer Crusade.

The advertising space which you contributed this spring was of significant help in our nationwide educational and fund raising drive, which has been the most successful we have conducted. Present reports indicate we will go over our goal of $16,000,000.

We are very grateful for the assistance you have given to the fight against cancer.

Sincerely yours,
William J. Donovan,
Chairman, Board of Directors



"YOUR DOCTOR," a fifteen-minute educational film concerning the medical profession, soon will be shown in a number of Connecticut theaters.

Produced in cooperation with the American Medical Association, the film tells the story of Dr. George Bond's North Carolina mountain clinic, of how medical students are trained and of the relationships between physicians and their medical societies.

It is estimated "YOUR DOCTOR" will be seen by more than 30 million people in five thousand community theaters in the next few months.

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette J. Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon
John O'L. Nolan, Hartford

Hartford County Sponsors First Hospital-Medical Education Day

The Hartford County Medical Association will sponsor a Hospital-Medical Education Day October 27. The program is being planned in cooperation with the Parent-Teacher Association and three Hartford hospitals, St. Francis, Mt. Sinai, and Hartford Hospital.

PTA members will be conducted on tours of the three hospitals as part of the day's activities. Representatives of the medical association and hospital staffs will explain the operation of hospital departments and parents will participate in a question and answer period following the several tours.

Preceding the hospital tours, representatives of the Hartford County Medical Association will speak briefly on medical education and training and the responsibilities that physicians assume in caring for their patients.

It is anticipated that 450 members of Greater Hartford's 15 PTA Councils will participate in the program.

Two New Publications Announced by AMA

The American Medical Association recently announced two new public service booklets.

The first booklet, "Your Money's Worth in Health," is designed to give the public pertinent facts on medical and hospital costs. Colorful and well illustrated, the text explains with the aid of unique charts the relationship of medical, hospital and drug costs. It compares the cost of medical services with other living costs and points out that the doctor's share of the medical dollar was 32 cents for the period 1935-39 as compared to 28 cents in 1950.

"Your Money's Worth in Health" is one of a series of booklets being produced by the American Medical Association for distribution to the public by physicians and state and county medical associations. Copies have been mailed to all practicing physicians in the United States, accompanied by return postcards so that extra copies may be ordered for reception rooms. Copies also may be ordered from the State Medical Society, New Haven.

Another booklet, "Doctor, Meet the Press," discusses the problems and techniques of releasing medical news for publication in newspapers and magazines. It was written by John L. Bach, press relations director of the American Medical Association. Addressed to physicians, it is a useful guide for sound medical-press relationships. The booklet is being mailed to all members of the American Medical Association.

Plans Underway for Showing "Your Doctor" in Connecticut Theaters

"Your Doctor," the 15-minute documentary film produced by RKO-Radio Pictures in cooperation with the American Medical Association, will be shown in Connecticut theaters starting in September.

A program to have the film booked in as many theaters as possible was recently initiated through county medical association public relations committees.

State and county medical associations throughout the country are joining in the project. It is anticipated that their activities will result in the film being booked in 5,000 theaters and viewed by 30,000,000 people.

Committee on Rural Health Plans Exhibits for County Fairs

The Society's Committee on Rural Health is planning an exhibit on health and medical care for display at a number of Connecticut's country fairs this fall, it was announced recently by Norman H. Gardner, East Hampton, committee chairman.

The committee sponsored a similar project last year and its success at that time has encourged continuance of this type of educational program. Space reservations are now being made for fairs to be held during September and October.

New Radio Program in Hartford County

A series of twelve weekly radio programs is being sponsored by the Hartford County Medical Association in cooperation with radio station WDRC.

Titled "Fair and Cooler," the series began July 26 and will continue each Saturday, 6:15 P. M., through October 11.

Recordings for the series were prepared by the American Medical Association's Bureau of Health Education. A number of these series are available without cost to county medical associations desiring to sponsor radio health education programs. Arrangements may be made through the Public Relations Section, State Medical Society.

New England Council Sponsors Exhibit at Eastern States Exposition

The New England Council of State Medical Societies will sponsor an exhibit on health and medical care during the Eastern States Exposition, to be held in Springfield September 14-21.

Space for the exhibit has been engaged adjacent to an exhibit of the Massachusetts State Medical Society. It marks the first time that New England's medical societies have participated in the Exposition, one of the leading events of its kind in this section of the country.

New Secretary's Booklet Solves Office Troubles

Many of the doctor's PR troubles begin right in his office. Patients complain that they are kept waiting too long, that the atmosphere in his office is cold and impersonal, or that medical bills are too high.

To help reduce such complaints the American Medical Association has prepared a public relations handbook for the doctor's secretary, receptionist, or medical assistant. Entitled "Winning Ways With Patients," the brightly illustrated booklet offers practical suggestions for reducing waiting time, billing and collecting medical fees, and working with patients.

Every physician in the United States will receive a copy of "Winning Ways With Patients" after August 1.

"Winning Ways With Patients" is ideal for use in courses for medical secretaries which may be offered at local colleges or commercial schools. Additional copies for use in such courses can be obtained through the AMA Public Relations Department.

THE DOCTOR'S OFFICE

Albert S. Atwood, M.D. announces the opening of an office for the practice of orthopedic and traumatic surgery at 400 Prospect Street, Torrington.

Bernard S. Brody, M.D. and Robert Ralph McDonnell, M.D. announce their association in the practice of neurological surgery at 235 Bishop Street, New Haven.

Salvatore R. Carrabba, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 179 Allyn Street, Hartford.

Gerald P. Fitzgerald, M.D. announces the opening of an office for the practice of general surgery at 179 Allyn Street, Hartford.

John L. Meunier, M.D. announces the opening of an office for the practice of urology at 24 Church Street, Torrington.

James F. McAndrews, M.D. announces the opening of an office for the practice of urology at 576 Farmington Avenue, Hartford.

John F. McGarry, M.D. announces the opening of an office for the practice of obstetrics and gynecology at 3589 Main Street, Stratford.

Raymond Schipke, M.D. announces the opening of an office for the practice of pediatrics at 576 Farmington Avenue, Hartford.

Edward Scull, M.D. announces the opening of an office for the practice of rheumatology at 576 Farmington Avenue, Hartford.

Don't Be a Part-Time Citizen

REGISTER! — VOTE!

Offering -- nationally famous makes of

FURNITURE, EQUIPMENT and SUPPLIES including:-

W. D. Allison Company

Shampaine Company

Ritter Company

Welch-Allyn Company

Johnson & Johnson

Armour Laboratories

Raytheon Manufacturing Co.

Birtcher Corporation

J. Sklar Manufacturing Co.

Davol Rubber Company

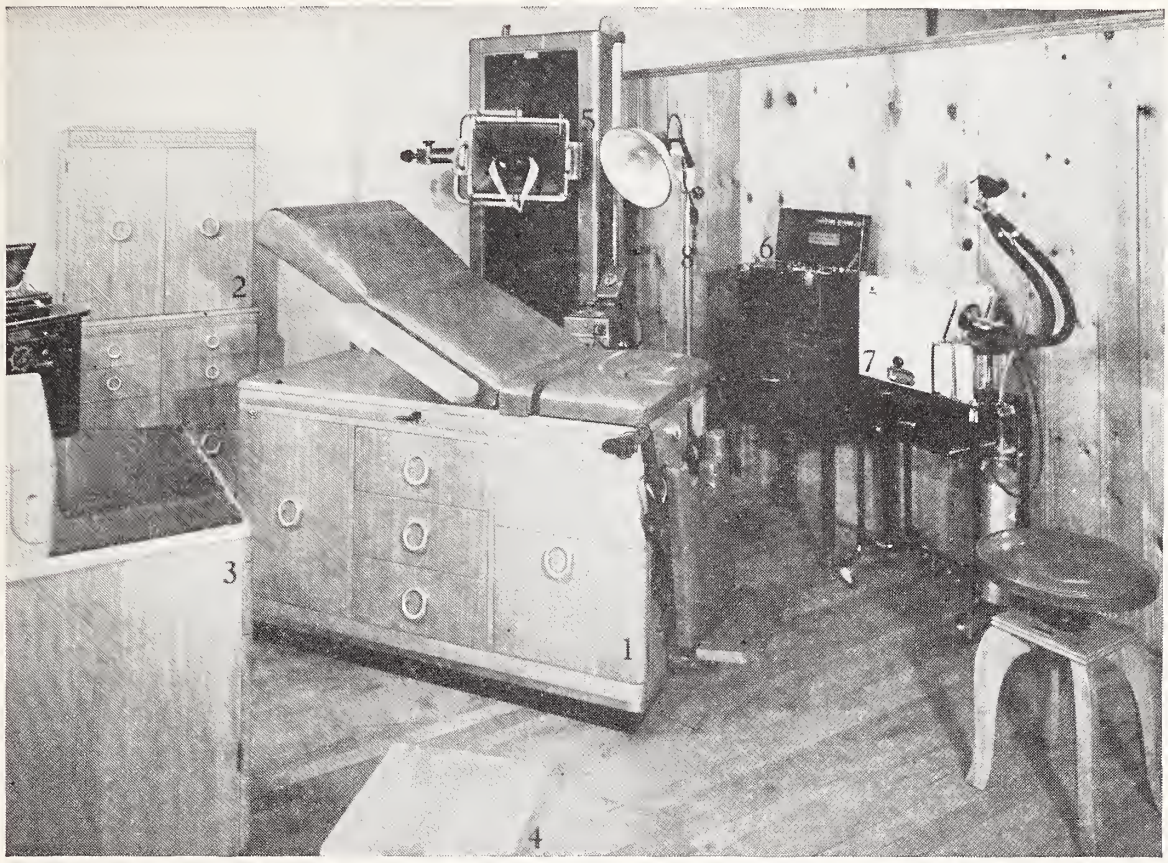
Seamless Rubber Company

Becton, Dickinson & Company

Americaine, Inc.

North American Philips Co.

and many others



One section of our large display room in Bridgeport

Telephone 5-3116 -- Enterprise 3190

American Surgical

SUPPLY and EQUIPMENT CO.

1715 BARNUM AVENUE P. O. BOX 150

BRIDGEPORT, CONNECTICUT

NEWS FROM WASHINGTON

Health Commission Schedules Hearings on Voluntary-Compulsory Insurance

Hearings on the controversial question of financing medical care have been scheduled for October 7, 8 and 9 by the President's Commission on the Health Needs of the Nation. Exponents of all health insurance proposals will be invited to testify, including groups and individuals who have been urging adoption of the Truman-Ewing plan for national compulsory health insurance.

Walter Reuther, UAW-CIO president and chairman of the Commission's panel on financing of medical care, will preside over the sessions, which will be open to the press and the public. The full Commission as well as panel members will be in attendance.

During August and September the Commission has scheduled open panel meetings in eight American cities. At each a member of the Commission will preside, assisted by a chairman from the particular region. Later the Commission will study stenographic transcripts of the regional meetings before drafting its final report, which is to be presented to the White House at the end of the year. At the panels, Dr. Magnuson has asked for "a broad representation of opinion from medical, labor, farm, consumer, educational, health and other groups" on regional health problems. Representatives of organizations will have 10 minutes each for oral presentations, but may file briefs of any length for insertion in the official record. Individuals who wish to be heard, however, are asked to submit a written brief in advance. From these the Commissioners will select for oral presentation those considered of most value.

Commerce Department Reports on Physicians' Income for 1950 and 1951

Survey of Current Business, Commerce Department publication, recently carried the results of the latest survey of incomes for physicians, dentists and lawyers for 1950-51. Physicians' incomes rose at about the same rate as the general public's income. The sample of 639 physicians is compared with the results of the major Commerce Department survey for 1949 in which replies from almost 30,000 physicians were used. The Department statisticians weighted the returns in some respects to give a more accurate final average, but did not cover every possible contingency. The chart below shows the mean net income of all physicians with certain Commerce Department breakdowns for the three years covered. Figures for 1949 are from the earlier study published in 1950.

	MEAN NET INCOME IN DOLLARS			PER CENT INCREASE		NO. OF CASES IN SAMPLE
	1949	1950	1951	1949-50	1950-51	
All physicians	11,058	11,538	12,518	4.3	8.5	639
Major independent	11,858	12,345	13,378	4.1	8.4	413
Major salaried	8,272	8,727	9,522	5.5	9.1	266
Non salaried	11,744	12,324	13,432	4.9	9.0	349
All salaried	8,434	8,794	9,542	4.3	8.5	165

WHO Study Notes Rise in Cancer Deaths During Past 50 Years

World Health Organization, in another in a series on evolution of mortality in Europe and certain other countries, reports an increase in the death rate from cancer and other malignant tumors during the first half of this century. Some of this increase, the report cautions, may be due to better diagnosis and the fact older people are living longer. The report was prepared by Dr. Marcelino Pascua of Spain, director of the WHO Division of Health Statistics. Findings include:

(1) Cancer mortality as manifested in crude death rates has clearly increased in practically all of the nations studied, including the U. S., (2) a pronounced increase in deaths in the older groups, particularly those over 70, (3) deaths from cancer of the buccal cavity, pharynx and neoplasms of the skin have not increased, (4) marked increase in deaths from cancer of the respiratory system, particularly among men in the last two decades, (5) cancer of the breast in women continues to increase, (6) deaths from cancer of urinary organs have risen, particularly among males.

Public Health Service Doctors Lose Military Status

Deletion of a section of the Emergency Powers Continuation bill in the closing days of Congress has shifted members of the commissioned corps of Public Health Service from military to civilian status. According to the PHS legislative representative, the change will mean that PHS doctors will be denied (a) uniform allowances, (2) survivors benefits, (c) death gratuity and (d) all other military benefits not specifically provided by law under the PHS Act. However, they will continue to receive the special $100 per month pay, may still discharge their military obligation by service in PHS and may not now be required to remain in PHS.

Go Slow on Fluoridation, House Report Recommends

Submitting its final report in July, special House committee that has been investigating chemical additives since June, 1950 urged communities to make haste slowly in adding fluorides to their water supplies as an anti-caries measure. "The committee is of the view," says the report, "that a sufficient number of unanswered questions concerning the safety of this program exists as to warrant a conservative attitude. . . . If communities are to make a mistake in reaching a decision on whether to fluoridate their public drinking water, it is preferable to err on the side of caution." Rep. A. L. Miller (R—Neb.), one of committee's two physician members, went further. He filed an additional report which implies that U. S. Public Health Service, by urging municipalities to fluoridate, is engaging in "propaganda."

Another official pronouncement recently by Federal Security Agency, in form of a policy statement issued by Acting Administrator John L. Thurston, is expected to give impetus to fluoridation of community water supplies. Briefly, it says that food processors are not courting liability when they use fluoridated water in manufacture, provided that its fluoride content is within limits recommended as safe by Public Health Service. (Many inquiries have been received, as result of national controversy over this anti-caries measure, from canners and other processors who were concerned that they might be liable to prosecution under Federal Food, Drug and Cosmetic Act if they used fluoridated water in products going into interstate commerce). Pointing out that FSA will regard properly treated water supplies as not actionable, the statement continues: "Similarly, commercially prepared foods within the jurisdiction of the Act, in which a fluoridated water supply has been used in the processing operation, will not be regarded as actionable under the Federal law because of the fluorine content of the water so used, unless the process involves a significant concentration of fluorine from the water. In the latter instance, the facts with respect to the particular case will be controlling."

1,827 Projects Now Approved Under Hill-Burton Expansion

Figures released in July by Public Health Service disclose that 1,827 projects have been approved for construction since Congress initiated Hill-Burton program just six years ago. This hospital expansion and improvement represents a total estimated outlay of $1,417,757,580, with U. S. Treasury bearing slightly more than one-third of cost. Already in use are 950 projects, with 774 under construction and 103 still in planning stages. In all, they will add 88,164 beds and 289 health centers, exclusive of 58 health centers to be operated in conjunction with general hospitals.

U. S. Wins Major Decision in Hoxsey Cancer Battle

Decision handed down recently by Federal appellate court in New Orleans, granting an injunction sought by Food and Drug Administration to curb traffic in Hoxsey Clinic cancer medicines, is of front rank importance. It strengthens FDA's hand enormously in its continuing campaign against misbranded nostrums and, with regard to case in issue, precipitates a crisis of commercial survival for what probably is the best known cancer cure emporium in the country. Incidentally, this appellate ruling upsetting Dallas trial court decision which denied injunction to FDA, came in midst of Harry M. Hoxsey's libel suit against Dr. Morris Fishbein.

The decision in New Orleans administers a stinging rebuke to the trial judge (Atwood), repudiating his findings of fact and branding his denial of a restraining injunction to FDA as "an abuse of discretion." It attributes numerous errors to the lower court in its handling of the case, among them being the taking of testimony by laymen who claim-

ed Hoxsey's pink or brownish-black medicines, or both, cured their malignancies. Little or no weight should be attached, said the appeals court, to testimony on such a complex subject as cancer when it is given by laymen, since even experts can not prove its existence without taking biopsy material and making complete pathological tests.

Lower court is directed to grant the injunction against Hoxsey, whose principal Congressional supporter is Senator William Langer (R—N. D.). Whether Hoxsey will attempt to carry appeal to Supreme Court is unknown.

American Heart Association Seeks New Research Applicants

New research applications in the cardiovascular and related fields are now being accepted by the American Heart Association for studies to be conducted during the year beginning July 1953, it was announced by Dr. Louis N. Katz, chairman of the Association's Scientific Council.

Applications for Research Fellowships and Established Invesigatorships should be submitted by September 15, 1952. Applications for Research Grants-in-Aid may be filed up to December 1, 1952. Information and forms may be obtained from the Medical Director, American Heart Association, 1775 Broadway, New York 19, N. Y. Applications will be reviewed by the Research Committee of the Scientific Council.

Awards will be made from funds raised in the 1952 Heart Fund campaign by the American Heart Association and its affiliates throughout the nation.

Research Fellowships are open to graduates of approved medical and graduate schools who are interested in research and who plan to follow an academic career. Established Investigatorships are open to individuals of proven ability who have the degree of Doctor of Medicine, Doctor of Philosophy, Doctor of Science, or the equivalent, and who are interested in a career in research. Grants-in-aid are available to non profit institutions for a specified program of research including work in the basic sciences, under the direction of an experienced investigator.

The Research Committee recently voted to increase the stipends granted to Research Fellows and Established Investigators. Under the new scale, Research Fellowships, which are granted for a one-year period, range from $3,500 to $5,500. Established Investigatorships, which may be extended annually for a five-year period, range from $6,000 to $9,000. Grants-in-aid are awarded in varying amounts, usually not exceeding $10,000, and the period covered is variable, depending on the particular program of study.

Prescription Regulations Issued in Final Form: Disputed Points Omitted

Food and Drug Administration, acting through the Federal Security Administrator, has issued in final form a modified series of regulations bringing federal prescription requirements into conformity with the new Durham-Humphrey Act (P.L. 215, 82nd Congress). The new regulations: 1. Provide a labeling guide to manufacturers on directions for use of drugs. 2. Continue labeling exemptions for physicians. 3. Tighten up rules to make certain that prescription drugs are dispensed only by or on the prescription of a physician or other licensed practitioner. 4. Exempt certain habit forming drugs from the prescription only restrictions when used in non hazardous combinations.

The new regulations are an amended version of proposed regulations published in February. However, the new ones do not attempt to rule on certain points in dispute since February. Specifically, the final regulations make no mention of prohibiting sale by mail of prescription drugs, do not attempt to define toxicity and do not apply "method of use" as a criterion for prescription only designation (the proposed regulations listed all injection drugs except insulin as prescription—only).

FDA is reserving the right to rule on these controversial points in the future, but a spokesman said the agency did not wish to delay longer the official publication of regulations on which he said there is substantial agreement among the pharmaceutical industry and the medical profession.

The new regulations appear in the *Federal Register* for July 25 (Vol. 17, No. 145). Copies may be obtained from Food and Drug Administration, Washington 25, D. C.

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

'52 Graduates Delaying in Registering Under P.L. 779

Selective Service is showing anxiety over small increases in numbers of special registrants, medical and dental, but particularly the latter. Although June witnessed graduation of some 6,500 new M.D.'s and nearly 3,000 dentists, special registrant rolls increased only 2,329 and 462, respectively, during the month. SS suspects that a large number of recent graduates are forgetting or neglecting their legal obligation, under Public Law 779, to register with local draft boards under provisions of doctor-draft law—and do so within five days following graduation. Not required to become special registrants, however, are those new doctors who hold Reserve commissions.

June 30 Standings Reported

Monthly compilation reveals that on June 30 there were 96,178 special medical registrants, divided as follows: Priority I, 11,446; II, 2,720; III, 32,386; IV, 49,626. Dentists numbered 4,179 in Priority I; 777 in II and 14,728 in III, with no figure available on Priority IV. Induction pools comprised 1,189 physicians in I and 545 in II who had been placed in 1-A and were physically acceptable. Corresponding figures for dentists were 125 and 110. July callup of dentists, plus previously announced callup for September, will wipe out Priority I pool, which has lasted much longer than had been anticipated, and all but consume the II pool. Also, it appears probable that the Priority I reservoir of physicians—due to be exhausted this fall, according to previous estimates—will last well into 1953.

Military Doctor Turnover Entering Into High Gear

From now on, numbers of Reserve medical and dental officers returning to civil life after having completed obligated military service under doctor-draft law will rise steadily. Recently a rather spontaneous effort has been set in motion directed at establishment of a bureau, or clearing house, that would help these young physicians and dentists get readjusted and assist them in professional placement. Cooperating in the enterprise are AMA, ADA, Selective Service and the military, among others. A meeting to discuss implementation probably will be held in Washington in a few weeks.

Meantime, Department of Defense has announced it has requested Selective Service to order up 355 physicians and 90 dentists in September. Names of all M.D.'s will be drawn from Priority I category but dentists will be taken from Priority II, and some of them possibly from III. Army is scheduled to get 180 of the physicians, Air Force the remaining 175 and all 90 dentists.

Navy Reserve Medical Officers To Be Loaned

Lend-leasing of Naval Reserve dentists to Army and Air Force is beginning to proceed on a fairly large scale. Because its Reserve strength is so much greater than sister services', Navy probably will have to lend-lease some of its Priority II medical officers along about January and thereafter. To get maximum assurance they will be used in their own branch of the military, Naval Reserve physicians and dentists should request active duty orders promptly. It is estimated that involuntary callup of medical Reserves in Priority II will begin in November.

October Call for M.D.'s and Dentists Made by Military

Department of Defense on August 8 placed an official call on Selective Service to deliver 371 physicians and 200 dentists during October. Army is ticketed to receive 196 physicians and 110 dentists, remainder going to Air Force. Navy continues to rely on its still ample, though dwindling, pool of Reserves. October requisition is in addition, of course, to previously announced September call for

355 physicians and 90 dentists and the 450 physicians who have dates with their local draft boards this month. Latest request by Pentagon brings to totals of 1,893 and 850, respectively, the numbers of physicians and dentists which Selective Service has been directed to supply since July, 1951 under provisions of doctor-draft act.

SS's medical advisory committee is taking two steps to ascertain identities of doctors who have neglected to become special registrants as required by Public Law 779: Requesting state advisory groups to check boards of medical and dental examiners on newly issued licenses; sending questionnaires to hospitals which are asked to supply, among other data, information as to whether interns, residents and fellows are special registrants and whether they are members of Reserve.

Increased Compensation for Veterans

Almost 120,000 blind, crippled and tuberculous veterans of all wars and peacetime service will receive increased payments in their compensation checks due September 1, 1952 under Public Law 427 signed by the President June 30, Veterans Administration announced.

VA said the increases are automatic for those veterans who are receiving compensation checks for the disabilities specified by the new law. However, veterans who are not on the compensation rolls and are covered by the new law should apply at their nearest VA Regional Office.

The new law went into effect on August 1, and the increases will be reflected in the checks usually received by the veterans on September 1.

Veterans who will receive the increased checks are those who have been awarded statutory allowances for the loss, or loss of use, of either or both hands or feet, for blindness, and for total deafness (in combination with total blindness).

Veterans who are receiving a minimum monthly rate of compensation for arrested tuberculosis will also receive increased checks.

Statutory allowances are paid in addition to the basic compensation rates which are based on the degree of disability and range from $15.75 to $172.50.

The new bill authorizes for the first time for World War II veterans and veterans with service since the beginning of the Korean conflict a minimum monthly rate for arrested tuberculosis and a statutory allowance for the loss, or loss of use, of a creative organ. Up to now these benefits have been available under existing law to certain World War I veterans only.

The new law made the following increases for veterans disabled in wartime or since the Korean conflict started:

1. Monthly statutory allowance for the anatomical loss, or loss of use, of one hand, one foot, or blindness of one eye (having only light perception) increased from $42 to $47. This is payable in addition to monthly rate of compensation.

2. Monthly rate of compensation for the anatomical loss, or loss of use, of both hands, both feet, blindness, total deafness (in combination with total blindness), and various combinations of such disabilities increased from a range of $240 to $360, to a range of $266 to $400.

Additional amounts are payable for a wife, children, or dependent parents in these cases and in all other service connected cases where the veteran's disability is rated 50 per cent or more. The monthly rates of such additional compensation in totally disabled cases range from $21 to $91 depending on the number and type of dependents. The new law does not increase these additional amounts.

3. The minimum monthly rate of compensation for service incurred tuberculosis which has been arrested is increased from $60 to $67 and extended to cover World War II veterans and veterans with service since the start of the Korean conflict.

4. Monthly statutory allowance for loss, or loss of use, of creative organ is increased from $30 to $47 and extended to cover World War II veterans and veterans with service since the start of the Korean conflict.

5. Certain seriously disabled World War I veterans, with service connected disabilities, will receive increased monthly payments—from $198 to $220 for totally blind veterans; from $258 to $286 for totally blind veterans who have lost one or more limbs, and from $60 to $67 for veterans who need the regular aid and attendance of another person.

These new wartime rates also are payable for peacetime service if the specific disabilities were incurred in line of duty as the direct result of armed conflict or while engaged in extra hazardous service, including service under conditions simulating war.

Rates of compensation for disabilities incurred during other peacetime service are 80 per cent of wartime rates.

First Director of Armed Forces Medical Library Named

The appointment of Lieutenant Colonel Frank B. Rogers, MC—USA, as director of the recently established Armed Forces Medical Library has been announced by Secretary of the Army Frank Pace, Jr., with the concurrence of the Secretary of Defense.

Colonel Rogers has served as the director of the Army Medical Library, the forerunner of the new institution, since October 1949.

The Armed Forces Medical Library is the largest institution of its kind in the world. It will serve as a central medical library for the Army, Navy and Air Force and as a National Library for medicine and related sciences. The Library's extensive facilities will also be available to medical research and development contractors, other governmental agencies and civilian physicians and medical scientists of all countries.

As the Army Medical Library, the new establishment gained an international reputation through the publication of its Index-Catalogue, the most extensive bibliography of medicine in existence. Since it was first published in 1880, the Index-Catalogue has grown to 57 volumes issued in four series. It includes more than 2,800,000 subject references covering publications from the 15th to the 20th century and is a standard reference work in medical libraries throughout the world.

Because of the format of the Index-Catalogue, and the time lag inherent in publishing it, in 1950 the decision was made to phase out the remaining activities of this monumental bibliography and to substitute for it a monthly publication, the Current List of Medical Literature. This publication enables the Library to maintain an up-to-date bibliography of the world's medical literature.

The Library's more than 650,000 bound volumes, together with its vast collection of journals written in practically every known language, are the center of attraction to physicians and medical scientists from the four corners of the earth.

Functioning for the most part on a mail order basis, the Library receives requests for books, references and other material from all over the world. During the fiscal year 1951, more than 29,700 books were lent to borrowers in the United States. During that same period requests for information numbered 55,900. Through its photoduplication service, the Library is able to furnish microfilms or photostatic copies of desired material for a very nominal sum. Also available are microfilm copies of publications which may be obtained on a loan basis. The photoduplication service received 56,000 orders requiring over 1,500,000 pages of film and print reproductions during fiscal year 1951. The Library's use of microfilm as a medium for recordings of the latest developments in medicine was an important factor in enabling the Army Medical Service to keep its officers overseas informed during World War II; it is performing the same service today in Korea and other outlying sections.

Cost of Living Outruns Medical Care Expenses

Medical care costs are lagging well behind the rapid climb of the cost of living, according to a study made by the American Medical Association's Bureau of Medical Economic Research.

The finding, based on statistics presented by the United States Bureau of Labor Statistics, showed that in 1951 the price index on all items in the consumers' budget rose almost twice as many points as the price of medical care.

The cost of living index in 1951 for moderate income families in large cities was 185.6 (1935-1939 is considered a base level period equal to 100), according to Frank G. Dickinson, PH.D., Chicago, director of the bureau. This compares with 171.9 in 1950, or a rise of 13.7 points.

On the other hand, the medical care and drug index during 1951 was 155.0, as against 147.9 the year prior—an increase of 7.1 points.

"The consumers' price index cost of living has risen 86 per cent since the base period, while the price index of medical care has risen only 55 per cent," Dr. Dickinson stated.

Physicians' fees also have been climbing much slower than the cost of living, he added. The fee index last year was 145.2, representing an increase of 45 per cent over the base period, compared with the 86 per cent rise in living costs. In 1950, the fee index was 140.0.

The greatest rise has occurred in hospital room rates, Dr. Dickinson's report pointed out. This reflects soaring labor and material expenses, he added. The hospitalization index stood at 260.7 in 1951, as against 235.3 in 1950. The report stated, however, that the average hospitalization period has been declining steadily.

FROM OUR EXCHANGES

An editorial in the *North Carolina Medical Journal* (13.1) calls attention to the fact that North Carolina has been chosen for a pilot study on Financing Hospital Care. The objectives of a national study is outlined by the American Hospital Association as follows:

1. Evaluation of the current financial position of hospitals.

2. Determination of the need and demand for hospital services.

3. Analysis of the effect of medical practice on hospitals costs.

4. Establishment of means of obtaining needed high quality hospital services at the lowest possible cost.

5. Evaluation of systems of payment for hospital care.

6. Investigation of methods for facilitating the most effective utilization of hospital resources.

7. The Commission will make recommendations for accomplishing changes which appear desirable as a result of this study.

The progress and conclusions of this study should be followed by the practicing physician with interest and, it may be added, with close attention. The final recommendations of the group should be subjected to a critical analysis at the level of the formation of programs and of the implementations of policies.

This observation is not to be interpreted as having the meaning that the Commission is under suspicion or that its membership has a socialistic background. However, it can be asserted that the truth can only be hammered out on the anvil of criticism and debate; and that no restricted group, no matter how learned they happen to be, has all the answers to the puzzle of a better distribution of quality medical care.

* * * *

"Coronary Occlusion Before the Age of Forty" is discussed by John Smith in the *North Carolina Medical Journal* (13.1). His conclusions are interesting.

1. Midline pain with or without radiation strongly suggests myocardial infarction or angina pectoris.

2. Midline pain with bilateral radiation should always be considered indicative of angina pectoris or myocardial infarction.

3. Reproducibility, repetition, and constancy of pain patterns are characteristic of angina pectoris.

4. Chest pain in women under 50 without hypertension is almost never due to coronary artery disease.

5. Unilateral left-sided pain which is not substernal is only rarely due to coronary artery disease.

6. False chest pains are not reproducible and occur often at night.

7. There is no consistant pattern characteristic of false pain.

8. Evidence of an anxiety state are almost invariably present in patients with false pain.

9. False pain can usually be relieved easily by reassurance and the administration of mild soporifics and an antispasmodic such as belladonna.

10. The administration of nitroglycerine is not valid as a therapeutic test for angina pectoris, because it commonly relieves spasm of the gastrointestinal tract as readily as it relieves angina pectoris.

11. The majority of false pains are due to spasm, and to gas in the colon, stomach or duodenum.

12. False pains are common even in patients with known coronary disease, and must be recognized and treated.

13. The correct differentiation of true and false chest pain will result in the proper therapy of those ill with coronary artery disease and will prevent the creation of innumerable cardiac neurosis.

* * * *

Finnerty and Freis *(Med. Ann. of D. C.,* XXI.2) have undertaken the "Clinical Evaluation of Vergitryl, A New Highly Purified Extract of Veratrum Viride."

Veratrum viride has been reported as having a beneficial effect on essential hypertension and the toxemias of pregnancy. The crude extracts of the drug did not permit standardization of dosage; and

undesirable side effects were frequent. A purified preparation which may be put up in a form that permits of either parenteral or oral administration suggested a clinical evaluation of the new drug. It is their conclusion that the availability of a purified form of veratrum viride has simplified the management of the hypertensive toxemias of pregnancy. The purified drug (Vergitryl) has the advantage of predictable response to standard dosage, and that it is no longer necessary to work out an individual titration for each patient. There is an added advantage in the fact that it can be given by the intramuscular route and that continuous intravenous injections are no longer necessary except in convulsive cases.

* * * *

William B. Bean in his "Remarks on Sudden Death" *(Jour. Iowa State Med. Soc.* XLII.2) summarizes the phenomenon in three ways:

1. The "instant physiologic death" which is an irrevocable syncope.

2. Death associated with ventricular fibrillation or asytole, characterized by violent respiratory effort, and then gradual respiratory failure over a period of many minutes; and finally

3. A group of nondescript cases in which death occurs as an unexpected event, taking hours from the time of the beginning of symptoms which mark the introduction of the lethal scene to the final and terminal stage of the picture.

In all such cases it is important that we are aware of the procedures of resuscitation, ranging from the injection of drugs to opening the chest and massaging the heart. If we recognize the risk of sudden death and its different mechanisms under different circumstances, it will be possible, at least in an occasional instance, to intervene and to restore life to someone who apparently has died.

* * * *

Gendel et al *(Amer. Prac.* 3.2) report that in the treatment of 25 cases of acute leukemia with Aminopterin they only obtained two remissions (one complete lasting six months and one partial remission lasting four months); and that toxic reactions were frequent. The toxic reactions included ulcerations of the mucus membrane, anorexia, nausea, leukopenia and hemorrhagic manifestations.

* * * *

"Cardiac Arrest Under Anesthesia" is a subject that is ably discussed by Stilwell and Mueller in the *Journal of the Indiana State Medical Society*, 45.2. The article may be too briefly summarized as follows:

1. Artificial respiration with 100 per cent oxygen and maintainance of an open airway must be the responsibility of the anesthesiologist.

2. Immediate cardiac massage by one of three routes must be the responsibility of the surgeon. The routes include (a) transperitoneal subdiaphragmatic, (b) transperitoneal transdiaphragmatic, and (c) transthoracic.

3. General supportive therapy, including intravenous administration of fluids and the establishment of fifteen degrees of Trendelenburg's position, must be the responsibility of a third member of the team. This third member of the team may also be given the responsibility to attend to intra-arterial transfusion if given.

4. Drug therapy is the responsibility of the surgeon but the preparation of such material is the responsibility of the nursing staff. The kit consists of one long cardiac needle, two 5 cc. syringes, two twenty gauge needles, one ampule of 1:1000 epinephrine and two ampules of 1 per cent procaine (6 cc. each).

There are two methods outlined. (a) Procaine in a 2 per cent solution is injected directly into the right cavity of the heart, meanwhile continuing the cardiac massage. (b) A long cardiac needle is immediately inserted into the heart by the surgeon. If the heart is beating the surgeon injects 4.75 cc. of one per cent procaine and 0.25 cc. of 1:1000 epinephrine. If after three to five minutes there is no cardiac response, a second injection is given. Following this a continuous drip of procaine may be started. Epinephrine should never be repeated.

Drug therapy has a role in this condition, but only in the late stages of treatment and only after the establishment of the diagnosis and the institution of a patent airway and cardiac massage have been begun.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
First Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville

Resolutions Adopted at the 1952 Convention of the Woman's Auxiliary

The resolutions adopted this year at our national meeting are of such importance that it is the feeling of your State President that each auxiliary member, or prospective member, should be aware of them.

The program as set forth by these resolutions is being carried out successfully by state and county auxiliaries across this nation of ours. Those of us who are active at state levels are making every effort to carry out that program in Connecticut.

To interpret and coordinate the goals as set forth by our national executive board, a "School of Instruction" is being planned for all Auxiliary state and county officers and chairmen, to be held in New Haven on September 9.

Lillian L. Freedman, President

I

Whereas, The great need for prepaid medical insurance continues to grow; and

Whereas, The administration has appointed a "committee to investigate the nation's health;" and

Whereas, The socialist planners make an issue of this topic in pushing laws for socialized medicine; and

Whereas, The AMA attempts to meet this need and at the same time block the trend toward socialism by setting up a system of voluntary health insurance;

Therefore be it Resolved that the Woman's Auxiliary to the AMA urge its component state auxiliaries to use every possible means to educate the public in the program of the AMA, that they urge their members to join lay groups, serve on program committees, become active in civic projects and stimulate lay assistance and participation in this program.

II

Whereas, The Auxiliary educational leaflets on the departments of the AMA have proven helpful in educating our women in the organization and program of the parent organization; and

Whereas, This information would not otherwise reach us with its resulting understanding;

Therefore be it Resolved that the Auxiliary continue producing and distributing these leaflets.

III

Whereas, The Committee on Civil Defense has proven such a useful and successful one;

Whereas, The committee has succeeded in creating an interest in defense among the auxiliaries with a corresponding constructive response and participation; and

Whereas, The emergency which created the need for this committee continues to exist;

Therefore be it Resolved that a Civil Defense Committee be continued as long as there is a need for it.

IV

Whereas, We, as wives of physicians, realize, probably more fully than members of lay families, the great work being accomplished by the transfusion of blood not only for the ill in our hospitals but for the boys on the field of battle and in the military hospitals;

Therefore be it Resolved that Auxiliary members not only help with the work of the blood banks but also urge people, both singly and in groups, to donate blood as often as possible.

V

Whereas, The elections to be held this year on both state and national levels will vitally affect not only the practice of medicine and the welfare and future of our country but also the course of world history; and

Whereas, We, as women, are directly affected by the kind of government we have and can make our force felt only through exercising our voting privilege;

Whereas, Dr. Walter Judd told us, at the Mid-year Conference, that we must approach these things not only as medical people, but as citizens; and

Whereas, We realize that the way to be effective as citizens is through politics;

Therefore be it Resolved that each of us shall accept this challenge and do all we can to inform ourselves and our neighbors that all may vote more intelligently for the preservation of this constitutional government of ours.

Be it Further Resolved that whenever it is possible or practicable our women be urged to take their place in government by running for the legislature, school boards and other offices.

VI

WHEREAS, The great need for nurses continues to be acute and good medical practice requires more nursing care for patients as well as assistance for the medical profession in every field;

THEREFORE BE IT RESOLVED that we, as an organization, do all within our power to stimulate interest in careers in nursing, offer scholarships and otherwise induce entrance into this profession.

VII

WHEREAS, There continues to exist an acute shortage of nursing services in this country, even to the restriction of hospital programs because of this shortage; and

WHEREAS, The need could be partly filled and the great strain relieved by the use of qualified practical nurses who are being produced by their accredited schools;

THEREFORE BE IT RESOLVED that the Auxiliary to the AMA encourage women to equip themselves to become practical nurses through the program sponsored by the National Association for Practical Nurse Education and that we recommend to the American Medical Association that they consider more extensive use of these nurses.

VIII

WHEREAS, It is most important that every American citizen exercise his right to vote; and

WHEREAS, Adverse publicity has been given to the medical profession by proclaiming its lack of interest in government affairs and voting;

THEREFORE BE IT RESOLVED that each auxiliary, on the local level, be urged to appoint committees to investigate whether the medical families are registered and have voted and thus be in a position to refute the unjust claims and at the same time bring the percentage of voters up by a gentle reminder to those who have been negligent.

IX

WHEREAS, Health Days are being held in various parts of the country and are becoming increasingly popular; and

WHEREAS, The American Medical Association is interested in the promotion of all health activities; and

WHEREAS, It is logical that the Woman's Auxiliary to the American Medical Association should take an active part in all such interests;

THEREFORE BE IT RESOLVED that the Auxiliary on the state and local levels be urged to offer leadership and support to both urban and rural Health Days.

X

WHEREAS, This country was founded on the principles of liberty and dignity of the individual; and

WHEREAS, These principles resulted in developing a thrifty type of individual, self-sufficient and unafraid; and

WHEREAS, This way of life developed a philosophy resulting in the greatest potential in industry the world has ever seen to say nothing of the accomplishments in pure science and medicine, engineering and agriculture;

THEREFORE BE IT RESOLVED that the Woman's Auxiliary to the American Medical Association use its influence to teach the principles upon which our country was founded, with the resulting accomplishments, in our homes, our schools, our churches, our organizations and everywhere to the end that the flame of liberty may not be extinguished and that posterity may have the benefits for which our ancestors worked and fought.

XI

WHEREAS, Medical research of vital importance to the health of our people can be accomplished only through animal experimentation; and

WHEREAS, This work is done under complete anesthesia and only with the use of unwanted animals; and

WHEREAS, By using said animals medical science is advanced and lives are saved;

THEREFORE BE IT RESOLVED that the Auxiliary go on record as approving the Metcalf-Hatch Bill passed by the New York legislature and urge the passage of similar legislation by other states.

BE IT FURTHER RESOLVED that its members be urged to help educate lay groups to this need.

XII

WHEREAS, Numerous requests are being received for the use of the mailing lists of this Auxiliary; and

WHEREAS, Such requests will undoubtedly become more frequent and more urgent during this year of political campaigns;

THEREFORE BE IT RESOLVED that auxiliaries on the state and county levels adhere to the policy already set up by the national Auxiliary prohibiting the use of the name of the Auxiliary, the name of any officer of the Auxiliary in her official capacity, or the use of the mailing lists of any Auxiliary at any level for any purpose, except as requested to do so by the state or county medical associations; and

BE IT FURTHER RESOLVED, however, that members of the county auxiliaries be encouraged to assist in all nonpartisan "get-out-the-vote" drives.

XIII

WHEREAS, Statistics are making us more aware of the problems presented by accidental deaths and disabilities; and

WHEREAS, We know that many of these accidents which occur on farms, highways and playgrounds and in the schools, factories and homes are avoidable; and

WHEREAS, We are aware that many of these accidents are due to lack of information, misinformation and neglect, and

WHEREAS, A major objective of the Woman's Auxiliary to the American Medical Association is health education;

THEREFORE BE IT RESOLVED that the Woman's Auxiliary to the American Medical Association support, through the individual efforts of its members, programs in their local communities by other organizations to decrease these unnecessary deaths.

Omitted from Roster
(see August 1952 issue)

DANBURY

Mrs. William M. Stahl, 343 Main Street.
Mrs. William M. Stahl, Jr., Ohehyahtah Place.
Mrs. Felix F. Tomaino, 82 Deer Hill Avenue.

Hospital Costs

From Bulletin of Almeda-Contra Costa Medical Association

"This bill is terrible, and I'm not going to pay it." The hospital cashier was having a bad time with the husband of a patient. "How can you expect a working man like me to pay $128 for three days of care? What we need is hospitals run by the government."

The man's wife had been brought into the hospital for an emergency appendectomy three days before. The bill, broken down, covered $52.50 for the room for three days; $60 for the surgery; $10.50 for routine laboratory; and $5 for drugs, etc. The man did pay the bill finally . . . a little sheepishly and shamefacedly, after he was favored with a cool and friendly analysis of the charges and a comparison with his own economy.

* * * *

The man was a plumber. He was asked, first, if the service his wife received was satisfactory, and he agreed that the meals were good, the linen clean, the nurses were courteous, competent, the hospital was obviously carefully and effectively operated in every way. He had no complaint as to the prompt and competent treatment of the patient.

* * * *

"What would it cost the hospital," he was asked, "if you were to provide it with plumbing service over a continuous three day period?"

"Plumbers rates are $22 for an eight hour day," he replied.

"What about the two night shifts," he was asked.

"Those would be at double time. That would be $44 each."

"So the cost for one day of constant attendance by one plumber would be $110."

"That's right. And for three days it would be $330."

"And that's for wages alone. It doesn't include material. It takes more than 400 full-time employees to operate Peralta Hospital . . . 2½ employees for every patient, or 5/6th of one person's efforts, around the clock, for your wife. In addition to this time, the hospital supplied food, linen, medication, surgical equipment, laboratory services, telephone services, dressings and techniques and skills which are at least as specialized as those of a skilled trade such as plumbing. In addition, the hospital assumed a tremendous responsibility for the safety of your wife."

There was a pause. "Do you still think the bill was too high?"

"For the first time," he said, "someone has taken the time to explain hospital charges to me, in language I can understand."

As gracefully as he could, the husband went out and paid his bill. He left with good feeling. The incident inspired some further analysis of comparative hourly costs of hospitalization compared with going rates among skilled trades. An electrician's rate per hour is $2.75; a machinist's $2.41; a teamster's $1.81; a laborer's $1.70. An analysis of 70,516 patients admitted to Bay Area Hospitals during 1951 represented 374,027 patient days, or 8,976,648 patient hours. Total money paid by these 70,516 patients was $10,003,042, a cost of $1.11 per hour, for all hospital services, including laboratory, surgery, etc.

Connecticut Health League Favors Fluoridation

At a recent meeting of the Connecticut Health League, held at the University of Connecticut, Dr. Robert E. Schneider, chairman of the Health Education Committee, presented the following resolution which was prepared by his Committee:

"The Health Education Committee of the Connecticut Health League, recognizing the values which would accrue to the people as a result of the fluoridation of the public water supplies in the State of Connecticut, hereby propose that the Connecticut Health League go on record as favoring the procedure of fluoridation of the public water supplies of this state."

In addition to the constituent organizations of the League listed at the bottom of this letterhead, the Connecticut Section—American Academy of Pediatrics was admitted to the League at the recent meeting and all three of the delegates named by the Academy were present. These delegates are Dr. John B. Griggs, Hartford; Dr. James H. Root, Waterbury; and Dr. Edward T. Wakeman, New Haven.

SPECIAL NOTICES

STATE SOCIETY OF ANESTHESIOLOGY

A meeting of the Connecticut State Society of Anesthesiology will be held at the time of the 27th Connecticut Clinical Congress in New Haven on Thursday, September 18, 1952.

There will be an open meeting of the Committee on Anesthetic Morbidity and Mortality at 4:30 P. M., followed by the business meeting, dinner and the scientific session. The speakers at the scientific session, and the titles of their papers, will be as follows:

Leopold W. Trifari, M.D.; Pierino F. D'Elia, M.D.; Mario L. Garofalo, M.D.; Ulysses V. Golia, M.D.; and Norton A. Kazanjian, M.D., Hospital of St. Raphael, New Haven

Stellate Ganglion Block and Its Relation to Cerebrovascular Accidents

Sawyer E. Medbury, M.D., Windham Community Memorial Hospital, Willimantic

Prophylaxis of Thromboembolism in Selected Patients—A Preliminary Report

Frank H. D'Andrea, M.D., Stamford Hospital, Stamford

Experiences with Therapeutic Nerve Blocks

Doris C. Grosskreutz, M.D., Grace-New Haven Community Hospital, New Haven

Succinylcholine—A Step Nearer to the Ideal Muscle Relaxant

William B. Lyons, M.D., and Arthur J. Adams, M.D., Charlotte Hungerford Hospital, Torrington

The Use of Procaine and Curare in Acute Back Syndrome

SPEAKERS AND CLINICAL CASE CONFERENCES IN OPHTHALMOLOGY AT YALE UNIVERSITY SCHOOL OF MEDICINE, 1952-1953

1952

October 10

Case Presentation—Exophthalmos

R. M. Fasanella, M.D., chairman, Department of Ophthalmology, Yale University School of Medicine

October 31

Rheumatism and the Eye

Joseph Igersheimer, M.D., consultant in ophthalmology, Boston City Hospital and New England Medical Center

November 14

Case Presentation—Diabetes and Eye Photography

Ernest Rosenthal, M.D., Hartford, Connecticut

December 5

Regeneration of Surgical Wounds After Intraocular Operations

Brittain Ford Payne, M.D., clinical professor of ophthalmology, New York University.

December 12

Case Presentation—The Management of Complications in Cataract Surgery

Arthur M. Yudkin, M.D., clinical professor of opthalmology, Yale University School of Medicine

1953

January 9

Case Presentations

Francis P. Guida, M.D., assistant clinical professor of ophthalmology, Yale University School of Medicine

January 30

Round Table Discussion of Surgical Problems and Their Management

Edmund B. Spaeth, M.D., chairman, Department of Ophthalmology, University of Pennsylvania, Graduate School of Medicine.

February 13

Case Presentations

Clement C. Clarke, M.D., assistant clinical professor of ophthalmology, Yale University School of Medicine.

February 27

Surgery of the Lacrimal Mechanism

Byron Smith, M.D., assistant clinical professor of ophthalmology, New York University School of Medicine

March 13

Case Presentations

Frederick A. Wies, M.D., assistant clinical professor of ophthalmology, Yale University School of Medicine.

March 27

Retinal Detachment

Charles A. Perera, M.D., assistant clinical professor of ophthalmology, Columbia, P. & S.

April 10

Case Presentation—Lacrimal Gland Tumors with Discussion of Pathology.

David Freeman, M.D., assistant clinical professor of ophthalmology, Yale University School of Medicine

April 24

Suspensory Ligament of Zinn and The Zonular Chamber

Henry Minsky, M.D., attending in ophthalmology, Mt. Sinai Hospital, New York City; associate clinical professor of ophthalmology, Columbia P. & S.

May 8

Case Presentation—The General Surgeon in Eye Lesions

William H. Ryder, M.D., head of Department of Ophthalmology, Hospital of Saint Raphael, New Haven, Connecticut

May 22

Differential Diagnosis of Hemianopia

Alfred Kestenbaum, M.D., associate, Presbyterian Hospital; consultant neuro-ophthalmology, New York Eye & Ear Infirmary; associate, City Hospital, New York City.

Postgraduate Course in Ophthalmology. Dues: $15. Dr. Frederick E. Mott, Treasurer, 38 Trumbull Street, New Haven, Connecticut.

HEART CONFERENCE SEPTEMBER 17-18

A Regional Conference of the various Heart Associations of the New England States will be held at the Northfield Hotel, East Northfield, Massachusetts on September 17 and 18, 1952 beginning at 10:00 A. M. on the 17th.

NEW ENGLAND TUBERCULOSIS CONFERENCE, SEPTEMBER 24-26

The Annual Meeting of the New England Tuberculosis Conference will be held at the Eastland Hotel, Portland, Maine, on September 24-25-26, 1952. The theme of the meeting will be "The Patient."

FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering to qualified individuals research fellowships in the basic sciences related to arthritis.

Fellowships will be granted on both the predoctoral and postdoctoral levels, and will run for one year with prospect of renewal.

The predoctoral fellowships will range from $1,500 to $3,000 per annum depending on the family responsibilities of the fellow, and the postdoctoral fellowships will range from $3,000 to $6,000 on the same basis.

The deadline for applications is November 1, 1952. Applications will be reviewed and awards made by February 15, 1953.

For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

NEWS
from County Associations

Fairfield

The semi-annual meeting of the Fairfield County Medical Association will be held at the Wee Burn Country Club in Darien on Wednesday, October 1. As usual the golfing members of the Association will have the facilities of the golf course for the annual tournament in the early afternoon. A business meeting will start at 4:30 P. M., followed by dinner at 6:30 P. M. The dinner speaker will be John M. Gleason, chief of police of the Greenwich Police Department. Chief Gleason is a past president of the International Police Chiefs and a lecturer at the F.B.I. Academy in New York. He was the representative of the U. S. State Department to Germany as an uncover man and will spend some time in his talk discussing this interesting investigation.

* * * *

The Alumni of Jefferson Medical College will hold a statewide Jefferson dinner for fellow alumni on Tuesday, October 7, at the Algonquin Club in Bridgeport. The speaker at the dinner will be Dr. John Gibbon, Jr., professor of surgery and surgical research at the Jefferson Medical College. Dr. Gibbon will address the Bridgeport Medical Association at the Bridgeport Hospital at the regular October meeting of the Association that same evening.

* * * *

Frank Turchik, attending otolaryngologist at St. Vincent's Hospital in Bridgeport, will address the Post-Graduate Convention in Ophthalmology and Otolaryngology in Winston-Salem, North Carolina on September 15. His paper is entitled The Diagnosis of Nasal Surgical Obstruction.

* * * *

A television set was presented to Henry S. Miles at a testimonial dinner given to the doctor on the completion of sixty years of practice. The dinner was attended by about sixty members of the profession.

Hartford

Hartford County doctors, for the first time in their 160 year history, held a precedent breaking "clinical session" with the members of the press and radio at a dinner given by the Hartford County Medical Association last June. John O'Leary Nolan, chairman of the public relations committee, explained that the meeting was planned so that county physicians could discuss with the radio and newsmen just how more and better public health and medical information could be relayed to the public.

Dr. Nolan said, "We hope to keep the public informed as to what is going on in our field."

News and radiomen, representing four daily newspapers and seven radio stations, generally agreed that no serious differences existed between them and the medical profession. Francis Ahern, city editor of the *Hartford Times,* said, "Lack of incidents between the doctors and the newspapers may be evidence that we have arrived at an understanding."

Some criticism of doctor shyness in attaching names to favorable publicity was answered by Dr. Benjamin Whitcomb. He said, "What is often dramatic and interesting to the public is many times a simple thing to medical men—and for a doctor to give his name to a story of that type makes him appear to be a glory seeker."

Radiomen pointed out that they would give time on the networks if they could obtain material from the doctors.

Thomas M. Feeney, secretary-treasurer of HC MA, stated that the executive secretary, Joseph L. Gordon, would handle this function and also serve as a clearinghouse for county news.

* * * *

An unanimous vote by HCMA directors approved the action of Dr. Feeney in releasing material to the *Courant* and the *Times* concerning doctor participation in local drug distributing firms.

Dr. Feeney, seeing the publication of a story in the *New York World Telegram* headlined, *Physicians Gouging Patients in Hookup With Pharmacists,* checked with the local papers regarding their use of this story. When they informed him that they would use the material, he then gave them a statement as to the stand of the county—which was already on record as warning its doctors against this type of scheme—in order to protect the physicians and offset unfavorable comment.

* * * *

A barbecue steak dinner featured the June meeting of the board of directors. William H. Upson, president of the county, invited the board to his home in Suffield to try his culinary ability over a barbecue pit.

The gastronomical satisfaction produced by the steaks enabled the directors to dispose of some highly complicated business in a little over three hours.

* * * *

Hartford County unveiled its first poster at the New England Health Institute at Storrs last June. The poster, finished in gray, maroon and white illustrated what the county is doing in the way of emergency telephone service, state activities, newspaper and radio programs and doctor-patient relationships.

The poster, three feet by four, was displayed with the Connecticut State Medical Society exhibit.

* * * *

Henry L. Birge was elected president of the Colonel Jeremiah Wadsworth Branch, Connecticut Society of the Sons of the American Revolution at their annual meeting held at the City Club in Hartford.

* * * *

Stevens J. Martin, head of the St. Francis anesthesiology department, presented a paper entitled "Anesthesia—A Challenge" before the AMA's Section on Anesthesiology at the June convention in Chicago. He also served as chairman of that group.

* * * *

Earl Terry Smith of West Hartford died at his home on July 23 at the age of 75 following a long illness due to malignancy. Dr. Smith had been a prominent eye, ear, nose and throat specialist for half a century, confining his practice to ophthalmology in his later years. He was a member of the Hartford Hospital Board of Directors.

* * * *

Elias J. Marsh, director of the Bureau of Mental Hygiene, State Department of Health since 1949, has succeeded Helen R. Gilmore of New Haven as president of the Connecticut Society of Psychiatry and Neurology.

Ralph Littwin has rejoined the staff of the Bristol Hospital as roentgenologist. Dr. Littwin has been engaged in private practice for several years.

* * * *

Donald A. Walker of Wethersfield has been appointed health officer for the Town of Rocky Hill to succeed Oran A. Moser. Dr. Walker has been assistant health officer for the past six years.

* * * *

Henry R. O'Brien, M.D. of Wethersfield is one of seven men and women from health sciences who have completed orientation training preparatory to embarking on Point 4 aid missions in 24 countries of Latin America, Near East, Africa and Asia. Dr. O'Brien will serve on the Ethiopian health mission.

* * * *

October 27 will mark Hartford County's first hospital-medical-PTA education day designed to show local PTA members the merits of the American free medical system as it exists in Hartford. At each of the three Hartford hospitals—St. Francis, Hartford and Mt. Sinai—parents will be guided through the various departments where representatives of the medical association and the hospital staffs will explain the work of central sterilizing, patient floors, operating rooms and the x-ray, laboratory and physical therapy set-up.

This will be preceded by brief talks from HCMA representatives on what is necessary to train a doctor, and his responsibilities to the patient. After the tour and a snack period, the parents will participate in a question and answer period.

Better than 450 people from the 15 greater Hartford PTA councils are expected to attend—and arrangements are now being completed so that the hospitals will be able to accommodate the groups.

* * * *

Fair and Cooler is the title of a new summer series of 12 radio programs over WDRC sponsored by HCMA. The first program in the series was broadcast, Saturday, July 26 at 6:15 P. M.

The whole series is prepared by the American Medical Association, and features Dr. W. W. Bauer, head of the AMA bureau of health education. Miss Harriet Hester, mistress of ceremonies and interviewer, introduces and questions Dr. Bauer. A short musical interlude is provided by Herbert Johnson, pianist.

William H. Upson, president of the Hartford County Medical Association, termed the series "an excellent, entertaining and informative program."

The broadcasting schedule for the entire twelve weeks covers Suntan, July 26; Sunstroke and Heat Exhaustion, August 2; Light Summer Meals, August 9; Keeping Cool, August 16; Exercise in Summer, August 23; Health in Swimming, August 30; Bugs, September 6; Water Safety, September 13; Hiking and Biking, September 20; Picnic and Business Lunches, September 27; Hay Fever, October 4; and Poison Ivy, October 11.

* * * *

The month of July was the end of HCMA's first six months of emergency telephone call operations. Total calls for the period—for Hartford, Manchester and New Britain—were 1,752. This figure does not include calls asking for information of one sort or another.

* * * *

Four members of the medical and surgical staff of the Hartford Hospital, Frederick L. Nichols, Sophie A. Root, Charles S. Mirabile and R. Starr Lampson, recently published an article, Cushing's Syndrome Treated by Removal of Adrenal-Cortex Tumor, in the *New England Journal of Medicine.*

New Haven

Medicine lost one of its stalwarts on July 30 when William T. Salter, chairman of the Department of Pharmacology at Yale, died of coronary thrombosis at Grace-New Haven Community Hospital. Dr. Salter had acquired a national reputation by his research studies on stable and radioactive iodine in connection with its effect on thyroid diseases.

News from Yale University School of Medicine

Harry S. N. Greene, professor of pathology at Yale addressed the 99th annual session of the Maine Medical Association on "The Significance of the Heterotransplantability of Human Cancer Cells."



Vein-Sparing

Parenteral Alimentation Facilitated with ALIDASE

For either rapid or slow administration of fluids, the use of ALIDASE®—highly purified hyaluronidase—places hypodermoclysis on a practical basis. When Alidase is added to the first few cubic centimeters of fluid, absorption from subcutaneous tissue is greatly facilitated. Injection is thus permitted at a convenient site with little or no swelling or discomfort, without arm boards and without many of the difficulties encountered with intravenous injection.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years*, are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

FOR SALE—Well established general practice 24 years duration located in enterprising city of western Connecticut; ground floor office. Will dispose of good will, all contracts at reasonable estimate of equipment, furnishings. Reason—removal, November 1, 1952. Write E.J.A. c/o CONN. STATE MEDICAL JOURNAL, 160 St. Ronan Street, New Haven, Conn.

For rent very desirable 4 room office space in vicinity St. Raphael Hospital, New Haven. Same building already occupied by dentist. Convenient parking. For further information please call SP 6-6117.



NEW BOOKS IN REVIEW

THE SCALP IN HEALTH AND DISEASE. By Howard T. Behrman, M.D., Assistant Clinical Professor of Dermatology, New York University Post-Graduate Medical School; Adjunct Dermatologist, Mount Sinai Hospital; Attending Dermatologist, Hillside Psychiatric Institute; formerly Associate Dermatologist, Bellevue Hospital, and Assistant Attending Dermatologist, University Hospital; Fellow in Dermatology, New York Academy of Medicine; Member, Committee on Cosmetics, American Medical Association; Society of Cosmetic Chemists; Society for Investigative Dermatology; Fellow, American Academy of Dermatology; Diplomate, American Board of Dermatology. *St. Louis: C. V. Mosby Company.* 1952. 554 pp. with 312 illustrations. $12.75.

Reviewed by MAURICE J. STRAUSS

At last a good, readable, authoritative book on the scalp and hair has been written. In this book the author has attempted to assemble much of the work on the scalp and its diseases. There is a need for such a book, as it has been many years since there has been one published on this subject.

The first chapter reviews the embryology, anatomy, anthropology, and physiology of the scalp. Included in this chapter is an excellent review of the relationships between endocrine and hair growth. The next chapter is a presentation on the care of the normal scalp and especially on the many products used by the laity in the care of the scalp and hair. This review is most useful. The subsequent chapters deal with the various disease states of the scalp such as alopecias, seborrheic states, infections, psychogenic diseases, primary skin and systemic diseases with scalp manifestations, and finally new growth. Concluding the book is a very extensive formulary of preparations for use on the hair and scalp.

The author has given an unbiased presentation of information. For the purpose of completeness he has included many theories which are not generally accepted.

He has covered his subject adequately and there is a good bibliography on the various subjects. The book will probably be of use mainly to dermatologists as it deals with theoretical aspects and is not primarily a book on therapy.

Dr. Behrman has marshalled all that he knows, all that he has read, what he has learned from his predecessors, and what he has learned from his own clinical experience.

PENICILLIN DECADE. By Lawrence Weld Smith, M.D., and *Ann Dolan Walker*, M.D. *Arundel Press, Inc.* 1951. $2.50.

Reviewed by PHILIP PARTINGTON

This book is an excellent review of the literature during the decade from 1941 to 1951 regarding the untoward reactions of penicillin during this period. It covers the ground completely, though somewhat briefly. Because of its brevity it would not serve as an authoritative source



To open congested air passages in hay fever

NEO-SYNEPHRINE®

HYDROCHLORIDE

. . . reduces nasal engorgement . . . relieves soreness

. . . promotes aeration . . . encourages drainage

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (1/8)% solution, bottles of 1/2 oz.; 0.5% water soluble jelly, in 5/8 oz. tubes.

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. & Canada, brand of phenylephrine.

book, but would serve as an excellent handy reference for the user of penicillin.

Its name is misleading as it in no way covers this tremendous period from the antibiotic standpoint or even from the standpoint of penicillin alone. It has no reference even to the enormous gain made in the practice of medicine by the use of penicillin nor of its multiple uses. If it had been otherwise named it would stand in its proper light, merely a reference book for untoward penicillin reactions.

THE TOXEMIAS OF PREGNANCY. (2nd edition.) *By William J. Dieckmann,* S.B., M.D., Mary Campau Ryerson Professor and Chairman of the Department of Obstetrics and Gynecology of the University of Chicago; Chief of Service of The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merritt Billings Memorial Hospital of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology. *St. Louis: C. V. Mosby Co.* 1952. 710 pp. $14.50.

Reviewed by Stanley B. Weld

Dr. Dieckmann has done a yeoman service in covering the subject of the toxemias of pregnancy in such a thorough and exhaustive fashion. He is a natural at the job and doubtless this fact was recognized when he was selected as an associate editor of the so-called "grey journal." The keystone of the entire volume is a sentence found buried well within the covers of the book. Here it is: "Every doctor who gives intelligent care to his pregnant patients has few or none with eclampsia and very few with severe preeclampsia."

The book is divided into six sections, the first covering the history, classification, incidence and pathology of toxemias of pregnancy. Not once but several times the author reminds us that the etiology of eclampsia is still unknown. He makes the striking comment that the patient with prepregnancy vascular renal disease is presumably more vulnerable to preeclampsia-eclampsia but seldom develops it. There has been a decided decrease in the incidence of eclampsia, but, with few exceptions, no change in the incidence of nonconvulsive toxemia. And then, too, Dieckmann believes that the number of deaths attributed to toxemia is probably less than the actual number because many such deaths are assigned to complications such as hemorrhage and sepsis. His review of reports appearing since 1940 confirms his belief that there are no specific pathologic lesions charactertistic of eclampsia or preeclampsia.

The second section deals with normal and abnormal physiology. The author reminds us that the treatment of eclampsia is still empirical and for this reason it is important to know that cold, anesthesia, morphine, histamine, high fever, etc., will intensify or perhaps initiate the blood concentration in a preeclamptic or eclamptic. In this section there is an excellent chapter on Physiochemical Determinations. A plea is made for more attention paid to the pathology of the placenta in determining the etiology of preeclampsia-eclampsia. Included is a report of studies done to show that restriction of sodium and potassium intake throughout pregnancy with the maintenance of a sufficient fluid intake will tend to prevent a recurrence of preeclampsia and even of its primary occurrence.

The third section is given over to the etiology of eclampsia. No correlation exists, according to the author, between pyelitis and preeclampsia or eclampsia. He even refutes Peters' work in New Haven where preeclampsia-eclampsia was shown to be identical with acute glomerulonephritis. Although Dieckmann makes the statement that diet seems to have little to do with preeclampsia, he has found that diets low in sodium and potassium seem to produce fewer cases of severe preeclampsia. He makes the shrewd observation that twenty-four hour supervision of a patient might prevent preeclampsia and eclampsia which, of course, implies that many of our patients do not follow our directions once they have left the office. Toxemia in two pregnancies is sufficient reason for prevention of further pregnancies.

The fourth and fifth sections cover the clinical aspects of the toxemias of pregnancy and the treatment of the same from the author's experience. In the last section there is a discussion of maternal and fetal prognosis and prenatal care. It is here that the author offers his concept of preeclampsia and eclampsia: viz., that it is a disease entity due to improper diet, faulty habits, abnormal environment, and an exaggeration of the normal physiologic changes of pregnancy. Preeclampsia-eclampsia rarely causes permanent vascular or renal pathology. About 10 per cent of eclamptic patients have a recurrence of convulsions in subsequent pregnancies while over 50 per cent of toxemic patients have normal subsequent pregnancies.

The author's classification of the toxemias of pregnancy is divided into disease peculiar to pregnancy (preeclampsia and eclampsia) and disease not peculiar to pregnancy (hypertensive disease, renal disease, and miscellaneous conditions simulating toxemia of pregnancy). The latest classification by the American Committee on Maternal Welfare lists three main divisions: acute toxemia of pregnancy, chronic hypertensive (vascular) disease with pregnancy, and unclassified toxemias. The two classifications are essentially the same.

This is an extremely valuable volume. The amount of reference material is stupendous, the author's own experience invaluable, and the publisher has offered this second edition attractively bound with a generous number of charts and illustrations and a type which is easy to read.

ORTHOPAEDIC APPLIANCES
BUILT TO
PHYSICIANS' PRESCRIPTIONS
ONLY

SHIRLEY BROS.
26 ASHLEY STREET, HARTFORD
Phone 6-3748

Braces - Belts - Etc.
ESTABLISHED 1910

Table of Contents : October 1952

Changing Role of the Physician in His Relationship With the Hospital of the Future — Gunnar Gunderson, M.D., LaCrosse, Wisconsin — 727

Congenital Toxoplasmosis: Case Report — Roy N. Barnett, M.D., Neil F. Lebhar, M.D., and Edmund F. Longworth, M.D., Norwalk — 731

The Diabetic Menu — Barnett Greenhouse, M.D., New Haven — 736

Nocturia in Malnutrition — Sidney Vernon, M.D., Willimantic — 739

Doctors and Lawyers in Court — Louis H. Cohen, M.D., New Haven — 741

EDITORIALS

For Your Information — 750
Hospital Problems and Doctors — 750
The Clinical Case Report — 751
Tinted Optical Glasses — 751
The Hospital Library — 752
Socialism by Treaty — 752
Anesthesiology, A Challenge — 753
Tuberculosis in Connecticut — 753
Cash Sickness Benefits For Two Out of Three Connecticut Workers — 753
A Successful Congress — 754

DEPARTMENTS

Progress in Clinical Medicine
Eye Emergencies and the General Practitioner
R. M. Fasanella, M.D., New Haven — 755
The President's Page — 759
The Secretary's Office — 760
Public Relations — 778
News From Washington — 781
The Historian's Note Book
The Medicine of Rudyard Kipling
George Blumer, M.D., San Marino, California — 765
Military Affairs — 788
From Our Exchanges — 790
News From County Associations — 805

MISCELLANEOUS

Programs—Semi-Annual County Association Meetings — 749
The Doctor's Office — 786
Special Notices — 800
The National Health Program; Statements by National and Congressional Candidates — 767

CONNECTICUT MEDICAL SERVICE

590,000*

MEMBERS

10th Largest BLUE SHIELD PLAN

in the United States

*90,000 new members since June

CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. XVI OCTOBER, 1952 No. 10

THE CHANGING ROLE OF THE PHYSICIAN IN HIS RELATIONSHIP WITH THE HOSPITAL OF THE FUTURE

Gunnar Gunderson, m.d., *LaCrosse, Wisconsin*

The Author. *Member of the Board of Trustees, American Medical Association*

I am very grateful to the members of the American Surgical Trade Association for the opportunity to speak on "The Changing Role of the Physician in his Relationship with the Hospital of the Future." As one of the participants in the panel, I assume that I am representing the organized medical profession of this country by virtue of my position as a member of the Board of Trustees of the American Medical Association. Many of the things which I may have to say, however, should not be interpreted as the official position of the American Medical Association, as obviously, there are many phases of this discussion upon which the American Medical Association may or may not have taken an official position or does take a definite stand. In other words, I am speaking to you as a practicing surgeon, with a background of over thirty years in active practice delivering medical and surgical service in a moderate sized community hospital. With the rapidly changing times and conditions it is perhaps presumptuous to even make any predictions with respect to the future. Certainly if I had attempted to make any predictions thirty years ago in respect to what conditions would be in A. D. 1952, I would probably have been perhaps a hundred per cent in error. I also feel that it may be presumptuous to talk to this group on the questions of hospitals generally, a subject with which most of you are more familiar than I am. I know of no group which is better acquainted with the hospital picture generally, than are the members of your Association who have the opportunity of obtaining first-hand information in the various hospitals throughout the country or in the trade areas where you have day to day contact with a large segment of the hospitals. By comparison at least, you are able to detect changes far in advance of a person who is, by necessity, limited in his connection with one institution most of the time. This is exemplified by my own experience where, often, my best source of information in respect to what goes on elsewhere is to talk with representatives of your group whom I see on their routine trips throughout the trade area. In this connection it has been my fortune to have become acquainted with several of the excellent representatives which some of the medical supply houses in the midwest have been sending out over these many years. I have in mind several who are my personal friends, in whom I have the greatest confidence, and who I would like to think are truly representative of the members of the American Surgical Trade Association.

To try to prophesy what the hospital of the future may be like is indeed a distinct challenge. From observation, it seems to me that there are many things which I regret seeing pass. Something is developing in regard to hospitals which we all regret seeing happen. I refer to the changes which are going on in hospitals, developing from a relatively small personal institution headed by a nurse superintendent who had a vested interest in running the entire institution from the administrative function, to nursing services, to food service, to laundry service and, virtually, the entire works. It was her hospital, and the nurses were her nurses and the doctors were her doctors. Hours meant practically nothing. Personnel was truly working in the spirit of Florence Nightingale, going about from day to day doing good. It is a long step to the present day situation where hospitals have developed into big

Given at the 50th Anniversary Convention, American Surgical Trade Association, Chicago, Illinois, June 5, 1952

business run by what is known as an administrator, be he a doctor or a lay administrator, functioning like a large modern day hotel, impersonal, departmentalized, practicing virtually no charity, the objective for which virtually all or most of them were established.

I view with alarm that the charity concept of the hospitals is rapidly becoming a thing of the past; in fact, recently I heard the statement made by a man high in the councils of the American Hospital Association to the effect that there is no good reason why a hospital could not be run so efficiently under present day charges that it could not be made into a good money-making institution. If such trend continues I am sure that there is every good reason why our taxing authorities should not deprive hospitals of their tax exempt status under the guise of being charitable or eleemosynary institutions. I view again with alarm another situation which has come about in the hospital picture in my generation. That is the problem of nurses and nurses training. No one in his right mind would quarrel with the increasing educational standards, both prenursing and nursing, which have been put into effect through the stimulus of the American Nursing Association, any more than I would decry the continually increasing standards of education and training for physicians. As far as nursing training standards are concerned, it is particularly true in regard to the nurses who are being trained for specialized duty where modern and complicated techniques are necessary. So it has perhaps become necessary to change nursing standards from those which were required by nurses when it was originally a vocational training to one which at present is of a standard which is comparable to a college degree or more. The practical effect has been that the service type of nurse has been almost entirely educated out of a job. It stands to reason that you cannot educate a person to the level of a college degree and expect a person elevated to this level to do the routine work around the bedside which, in the past, has usually been thought of as the prerogative of a trained nurse. If this trend of continually raising the standards of nursing education continues, it will undoubtedly become necessary to go backwards a step and train two classes of nurses: (1) The highly educated type of nurse who would be used for administrative purposes, for teaching, and putting into use the more specialized techniques and (2), the service type of nurse whose duty it would be to do routine work at the bedside. Indeed this trend is developing, whether one calls them practical nurses or nurses aids. What the American public needs more than anything else in the field of nursing care at the present time, in my humble opinion, are service nurses who are capable and willing to take care of the routine work necessary to a progressively aging population. And I might go as far as to say the crying need of the medical profession, which in the last years appears to be becoming altogether too specialized, is to develop more physicians who are willing to do general practice, what with fewer and fewer men going into the field of general practice, physicians who are capable of taking care of the run of the mine illnesses which probably constitute 80 per cent of the cases requiring care today. It is no mere accident that the largest and most actively growing medical organization in this country today is the Academy of General Practice, which, I am informed, has as one of its chief objectives, that of safe guarding the place of the general practitioner in the future hospital picture. There is ample reason for their mistrust of the hospital, hospital staff, and hospital administrators and hospital boards, when many hospitals have taken what appears to be the arbitrary position that no one but a certified specialist or one eligible for board certification is qualified as a member of the attending staff of a hospital. In the very near future this necessarily will be a pressing problem and calls for solution with the view of safe guarding the place of the general practitioner in the hospital picture of the future. I think it will be a long time before it will affect the small general hospitals in the rural and suburban areas, but as far as metropolitan centers are concerned, the problem is with us today. If the pattern of hospital distribution, as set up by the public health service under the Federal Security Administration, is carried to its logical conclusion, there may be a place for the general practitioner in the emergency hospital in the outlying areas and probably in the small urban areas. But certainly in the metropolitan centers it is difficult to conceive of the place the general practitioner would occupy in the hospital picture. This I think is exemplified in the highly socialized Scandinavian countries which I was privileged to visit last year. There the flow of traffic, as far as the patient is concerned, is pretty much as I have indicated. The faster this country progresses down the path of socialism and bureaucratic control, the faster this trend is going to develop. Be it good or evil depends upon one's attitude on social questions generally. As

far as I am concerned, it is tragic to contemplate such a change, giving up a level of hospital service in this country which is second to none for one which leaves much to be desired. The high standard of care which the Veterans Administration has been able to give, directly as a result of the reorganization which was created by Dr. Paul Magnuson when he was in charge of the Veterans Administration, by creating the Deans Committees and centralizing hospitals in the vicinity of teaching centers furnishes proof to the effect that the care is no better than the quality of men who are available for service in the Veterans Administration hospitals. The minute bureaucratic control begins to economize and runs the Veterans Administration program of medical care by economizing on the matter of staffing its institutions, the care in Veterans Hospitals will collapse to the same level as it was before World War II.

HOSPITAL INSURANCE AND MEDICAL CARE INSURANCE

One of the most significant developments in the total medical care picture during the past twenty years is the amazing spread of the prepayment hospital and medical care insurance program. At the time of the inception of the program it seemed to be the concensus that the saturation point was about 17 per cent. This gave the social planners ample support in their argument that the voluntary system would never work, but that the government would have to do it. After a brief period of fifteen years we see a picture where over 80 million persons in this country have some protection against hospital costs. Whereas, there are not as many who also have medical care coverage, the figure is rapidly growing and is almost paralleling the curve of the former, taking into consideration the later and slower start made by the Blue Shield. We cannot relax in our efforts of selling the American people on the principle of doing the job for themselves on a private initiative basis, and shouldering the responsibility of taking care of their own sickness costs in the traditionally American manner. Only in this way can we successfully defeat the socializers who would regiment the American people in the pattern of foreign ideologies. The critics of our plan say the coverage is inadequate, the coverage is not broad enough, and that it does not reach that segment of the population which needs it most. The medical profession is the first to recognize the fact that there are still defects in the plan, but these defects are capable of being remedied. These defects which readily come to mind are (a) coverage for the older age group; (b) coverage for long lasting illnesses. Already, in several areas in this country, particularly in California, the profession is conducting experiments in these areas. Solution, in my judgment, is purely a question of time. The sale of policies for this type of protection should not be made until and after sufficient and convicing actuarial data are available so that the financial solvency of any plan will be safeguarded.

RELATION OF PHYSICIANS AND HOSPITALS

One of the factors that has aggravated physician-hospital relationship is the inclusion of medical services in the contracts of voluntary hospital service plans. The medical profession is fostering voluntary health insurance and we believe that nothing should be done to disturb this very important and essential program. However, the American Medical Association has reaffirmed many times through its then Bureau of Medical Economics, its Judicial Council and the House of Delegates the principle that hospital service plans should exclude all medical service, and the contract provisions of such plans should be limited exclusively to hospital services. At the same time, so that there should be no misunderstanding as to which services should or should not be included, the House of Delegates has stated ". . . if hospital service is limited to include only hospital room accommodations, such as bed, board, operating room, medicine, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear (San Francisco 1938). Past actions of the House of Delegates give every reason to reiterate that radiology, anesthesiology, pathology and physiatry constitute the practice of medicine . . ."

In order to initiate a method for remedying this situation it is recommended that Blue Shield and Blue Cross be requested to cooperate to the extent of writing all new contracts in such a manner that Blue Shield will cover insurable medical services and Blue Cross will cover insurable hospital services. It is hoped that the professional and hospital authorities and the voluntary prepayment plans will cooperate in furthering these recommendations.

Since the physician and hospital are interdependent, it is incumbent on both to be interested in all phases of their scientific and financial relationships. This means that the professional staff of the hospital has very definite responsibilities toward not

only other members of the professional staff, whether active or courtesy, but also toward hospital management. The recommendations of the staff concerning medical matters are usually accepted by the management of the hospital through its board of managers or trustees. It must also be remembered that to be approved for residencies in specialties by the American Medical Association and the American College of Surgeons, certain requirements are mandatory to the institution, among them adequate pathologic and radiologic coverage. As a rule, the staff of a hospital elects an executive committee or works under an appointed executive committee to advise the lay officers of the institution on purely professional matters, and recommends who may or may not use the institution for professional work. Unfortunately, in many instances, the financial problems of the lay hospital management have been no affair of the staff or of its professional executive committee. This is wrong, and probably the cause of most of the differences of opinion between physicians and hospital management. The financial problems of an institution in which a physician does his professional work are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems if the hospital is to work efficiently and remain the workshop of the physicians, and without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff.

Every professional man on the appointed staff should have a voice in the professional management of the institution. The pathologist, roentgenologist, anesthesiologist and physiatrist, as well as the other professional staff members, should have equal standing as active members of the staff with all the rights and privileges pertaining to the other members of the staff of equal standing. The chiefs of these departments should be nominated and appointed in the same manner as are the chiefs of other major departments in the same hospital.

The revised Principles of Medical Ethics has been written with all these various factors in mind and is broad enough to cover all possible ethical physician-hospital relationships. The Constitution and By-Laws of the American Medical Association distinctly covers methods of procedure for all persons who have a complaint so that they may approach the Judicial Council. The functions of that Council are specifically delineated.

In the event of a controversy between physician and physician, or physician and hospital management on these problems, it is recommended that, since local conditions must be taken into consideration, these problems be resolved insofar as possible at the local level.

There can be no exploitation of the doctor or of the hospital if everyone concerned in management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public. In any given controversy, every effort should be made to settle the matter at the staff management level. In case of failure to settle the controversy at this level, assistance of the county medical society should be requested. If, then, it cannot be resolved, it should be submitted to a committee of the state medical association for advice and recommendation. If problems cannot be solved at the staff management level, through the county medical society, or through the state medical association, the constitution and by-laws of the American Medical Association provides that ". . . the (Judicial) Council, at its direction, may investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent association as it deems necessary . . ."

To implement the settlement of such controversies, it is recommended that each component medical society and each constituent state and territorial medical association appoint a committee on Hospital and Professional Relations. This committee should be available to receive complaints from any physician, hospital medical organization, or any other interested person or group with reference to professional or economic relations existing between doctors of medicine and hospitals. On receipt of such complaint by such a committee, the matter should be investigated and acted on in such a manner as will best effect adjustment of the complaint.

Another approach that should not be neglected in activating the settlement of difficulties is that of the local and state hospital associations. Most of the states and many communities have hospital associations providing direct representation for the hospitals within their areas. It seems reasonable to assume that state medical associations and component medical societies could well effect liaison

with these associations in the settlement of problems involving physician relationships.

In summary, the following general principles are suggested to individual physicians, county medical societies, and state medical associations as a basis for adjusting controversies, these principles, however, to be qualified to the extent required by the applicability of one or more of the factors heretofore mentioned:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where a hospital is not selling the services of a physician, the financial arrangement, if any, between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

Briefly, the answer to my assignment is that the medical profession is concerned with the basic problem of seeing to it that a hospital should not practice medicine, but be a place in which medicine is practiced.

CONGENITAL TOXOPLASMOSIS

Case Report With Review of Animal Contacts

Roy N. Barnett, M.D., Neil F. Lebhar, M.D., and Edmund F. Longworth, M.D., *Norwalk*

Toxoplasmosis is a widespread disease of man and animals[35] caused by a protozoan parasite. Most of the recognized cases have been found in newborn babies suffering from a fatal dissemination of the parasite. The brain is involved most extensively but other organs also contain the characteristic granulomatous lesions. Some infants recover and later exhibit a characteristic triad of mental retardation, cerebral calcifications and chorioretinitis. Although it is evident that many of the infants are infected in utero none of the mothers has shown any recognizable form of clinical toxoplasmosis during pregnancy. Unfortunately the placenta has not been studied in any reported human case. However, in the experimental congenital disease placental lesions are present.[26] Subsequent children of the mothers of congenital cases are usually healthy even though the mother's serum antibody titre may be high.[32] Cases presumably acquired postnatally also occur although these are rarer. They range in severity from presumptive infections demonstrable only by serological tests[23,24] to mild febrile disorders with skin rash or lymphadenopathy[37,38] and even to fatal examples.[5] The incubation period is not known in spontaneous infections but in human laboratory-acquired infections is brief, 19 days or less in one case and probably 3 days in another.[38] Diagnosis is often suspected clinically in infants with the characteristic triad and may be confirmed by complement fixation[24] or the serum dye test.[19] In autopsy material the organisms may be identified by their appearance or by passage to small animals. Although it is true that in spontaneous infections in animals there may be other organisms closely resembling toxoplasma, this is rare in man. The only very similar human parasite, the Histoplasma capsulatum, is always found intracellularly in phagocytic cells and associated with an inflammatory reaction, whereas the pseudocyst form

From the Divisions of Laboratories, Pediatrics, and Obstetrics and Gynecology of Norwalk Hospital, Norwalk, Conn.

of toxoplasma is often present in areas where there is no inflammation.

Because so many forms of mammals and birds have been found to harbor the parasite,[35] various animals have been considered possible sources of the human disease. In the authoritative opinion of Albert Sabin of Cincinnati,[32] dogs and cats are the commonest reservoirs for human disease and transmission is probably from the feces of the animals to the hands and mouths of human victims. Although some of these animals are obviously sick, others may be free of clinical disease.

CASE REPORT

CLINICAL HISTORY

This baby was delivered of a 28 year old woman, a resident of Westport, Connecticut, on June 1, 1951. In addition to the usual childhood diseases, the mother had colitis in 1930 and bronchopneumonia in 1937. She had one previous uneventful pregnancy in 1946 resulting in the birth of an apparently normal infant weighing five and one half pounds who was in good health on discharge of the mother but whose subsequent medical history is unavailable.

The present pregnancy was expected to terminate on July 11, 1951. In January, 1951 she had a chest cold which lasted for about two weeks, during which time she had a temperature of 100.2° F. Thereafter a chronic non productive morning cough persisted until delivery. Her blood type was O, Rh positive and the Mazzini test was negative. She was in good physical condition at the time of delivery. On May 31 she went into premature labor and was delivered of a living female infant weighing two pounds fourteen ounces. There was a partial placental abruption with bleeding and the placenta was retained necessitating manual removal. Her hospital course was uneventful and on checkup examination six weeks postpartum there were no complaints or evidence of disease.

The infant was well formed and breathed spontaneously. She was placed in an Isolette incubator. The cry was lusty and the baby active. Seven hours after birth respirations became shallow and the color dusky. The baby responded to artificial respiration but again became dyspneic at the eleventh hour when she had a generalized convulsion and died.

Autopsy—(performed by Dr. Ralph Lev, 6½ hours after death).

The body was that of a well developed, markedly jaundiced female infant weighing 1250 Gm. The lungs were fairly well aerated. The spleen was markedly enlarged, weighing 35 Gm. It was firm and dark purple-red in color with small corpuscles. The liver was large, weighing 83.5 Gm. It had a moderately firm consistency and a greenish color. The brain was soft and the cerebrospinal fluid slightly yellow. There was a moderate internal hydrocephalus. On section there were numerous scattered yellow, friable, necrotic areas up to 5 cm. in diameter. The other organs were not unusual on gross examination.

MICROSCOPIC

Heart—There was a very extensive focal myocarditis. In the involved areas, which included about half of the myocardium, there was loss of muscle fibres, with replacement and infiltration by an exudate in which plasma cells predominated. A few mononuclear phagocytes, eosinophiles and polymorphonuclears were present. A similar exudate was present in the epicardium and endocardium.

Lungs—Aeration was present but incomplete. There were scattered focal cellular infiltrations composed chiefly of plasma cells. They were few and small compared to those in the heart.

Spleen—The capsule was thin. The Malpighian corpuscles were few and small. The pulp sinuses were markedly congested. There were collections of plasma cells in the sinuses and in the cords of Billroth.

Pancreas—The usual immature acini and islets were present. Plasma cells and eosinophiles were scattered in moderate numbers in the stroma.

Liver—The architecture was still recognizable. The parenchymal cells were irregularly swollen and most contained yellow-brown pigment granules. The sinusoids contained numerous erythrocytes as well as focal collections of plasma cells, polymorphonuclears and eosinophiles and islands of hemopoiesis.

Adrenals—The cortex was largely composed of fetal x-zone. There were widespread focal areas of necrosis more marked in the inner cortex and medulla. Inflammatory cells included eosinophiles, plasma cells and polymorphonuclears in varying proportions.

Kidneys—There was the usual fetal architecture. There were some small focal infiltrations of polymorphonuclears and plasma cells.

Thymus—There were accumulations of plasma cells in the perithymic fat. The thymus itself was intact.

Brain—The changes in the brain were very marked in all areas sectioned. They consisted of areas of complete necrosis and inflammatory zones in which there was a heavy exudate of eosinophiles and plasma cells. A similar exudate was present in the meninges.

Parasites—The pseudocysts were identified in H & E stains of formalin-fixed tissue as oval bodies averaging 24 by 45 micra and filled with basophilic dots (Figure 1). They were readily found at 100 × magnification. At higher magnifications each dot was seen to be about 1 micron in diameter and surrounded by eosinophilic cytoplasm. Some parasites were also found singly or in very small groups. Here they tended to be ovoid or crescentic and up to 4 micra in length. The organisms were numerous in the brain and adrenal, rare in the heart and kidney, and not found elsewhere. Although they were most often found in areas of inflammation, some pseudocysts and single organisms were also scattered in areas of normal tissue.

SPECIAL STUDIES

Postmortem x-ray of the removed brain did not reveal any calcification. The brain and spleen were ground in a tissue grinder 17 hours after the autopsy, the organs having been refrigerated in the interim. Two cc. of the ground tissue

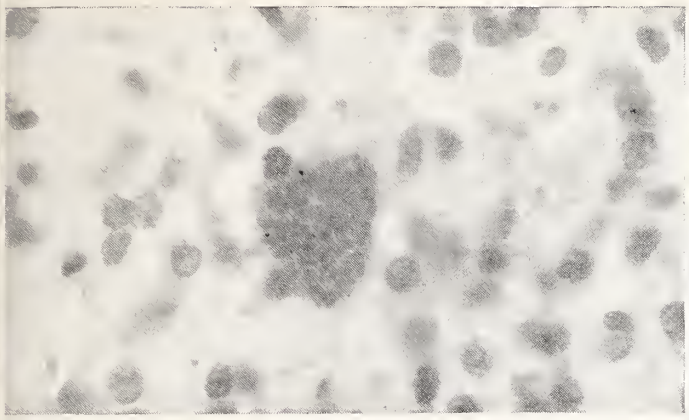


FIGURE 1
Pseudocyst of toxoplasma in adrenal of infant: oil immersion, Hematoxylin-eosin stain.

suspended in saline was injected intraperitoneally in each of two immature female rats. These were sacrificed after two and four weeks. No lesions were found. Blind passage of the organs of one of these rats into mice was also unsuccessful in demonstrating toxoplasma.

Blood drawn from the mother within a week after delivery contained complement fixing antibodies for toxoplasma and gave a titre of 1/4096 in the dye test.*

ANIMAL CONTACTS

One household pet was a dog who had always been well and whose blood two months after the baby's death contained no antibodies for toxoplasma. There were also two female cats. One of these was always well but the other developed periodic convulsions during the first trimester of pregnancy. Both cats had kittens about the time of the delivery. The kittens all seemed healthy and were disposed of without examination when they were about two weeks old. The mother cats were sacrificed by us ten days after the baby died. In the cat which had always been well there were no gross or microscopic lesions in the heart, lungs, spleen, liver, kidney or brain. In the cat which had had convulsions the organs were grossly normal. Microscopically there were no lesions in the spleen or kidney but there were focal lesions in the heart and brain. In the heart there were a few isolated areas of focal inflammation both in and between muscle fibres (Figure 2). The inflammatory cells were large mononuclears. Small ovoid basophilic bodies 2 micra in diameter in these areas were associated with necrosis and were thought to be fragments of leukocytes. In the brain (Figures 3 and 4) sparse focal lesions were present in the gray matter, white matter, meninges, and ependyma of the ventricles. They consisted of aggregates of mononuclear cells and lymphocytes.

Portions of brain from each cat were ground in a tissue grinder, suspended in saline and injected intraperitoneally in three mice. Individuals were sacrificed one, two and four

*We are indebted to Dr. Harry Feldman of the University of Cincinnati and to Drs. John E. Tobie, John Bozivech and Leon Jacob of the National Institute of Health for performance of these tests.

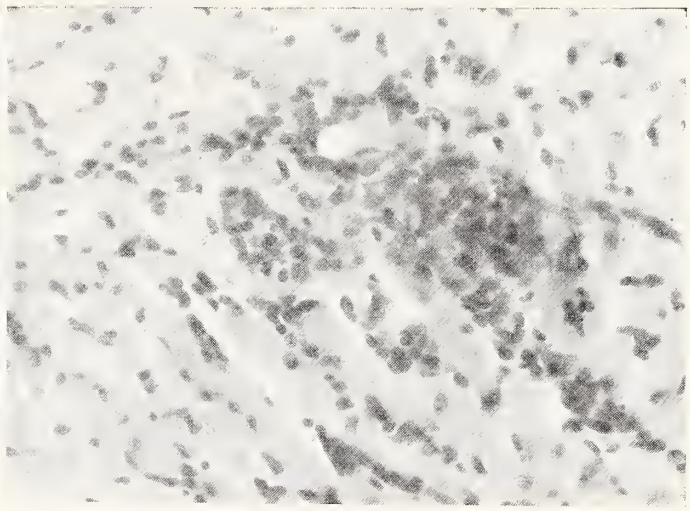


FIGURE 2
Focal myocarditis in cat: high power, Hematoxylin-eosin stain

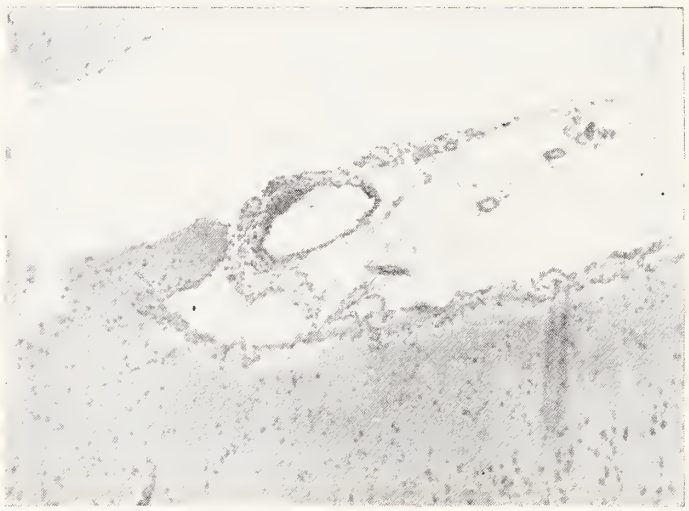


FIGURE 3
Perivascular exudate in meninges of cat; low power, Hematoxylin-eosin stain

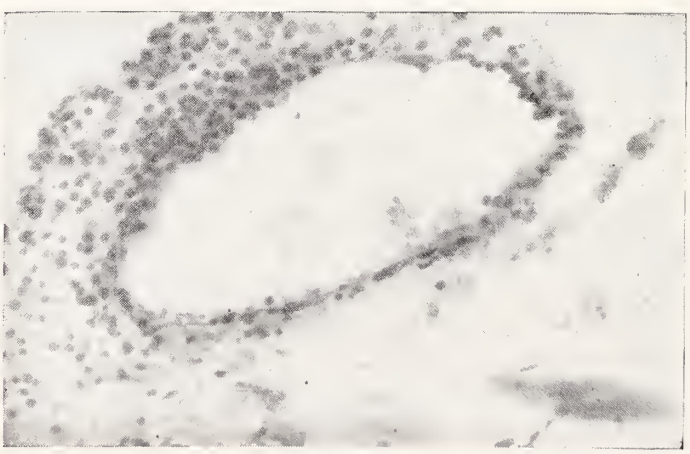


FIGURE 4
Perivascular exudate in meninges of cat; high power, Hematoxylin-eosin stain

weeks after inoculation. None showed any clinical illness or gross disease. Peritoneal smears from these mice made at autopsy and stained with Giemsa contained no parasites.

REVIEW OF THE LITERATURE

Because the mother of this infant was in contact with a sick cat whose lesions could be those of toxoplasmosis, we studied the reported cases in the English language to determine the incidence of animal contacts.

A total of 113 cases, including acquired and congenital disease, were reviewed. We included persons with positive serologic tests in the absence of symptoms only if they were closely related to clinical cases. There was no mention of animal contacts in 78 cases [1, 4, 8 (case 4), 9, 11, 12, 13, 15 (case 2), 20, 21, 22, 25, 28, 29, 30, 31, 33, and 36]. Animal contact was specifically denied in 8 cases [3, 6 (case 2), 7 (case 1), 8 (case 3), 16, and 37 (cases 4, 5 and 7)].

Contacts with animals not known to be sick were reported in 17 cases (Table I).

Table I

CONTACTS WITH HEALTHY ANIMALS OR VERMIN

REFERENCE #	NO. OF CASES	ANIMAL CONTACTS
#2, Case 1	1	Mice
#2, Case 2	1	Rabbits
#5	2	Ticks
#7, Case 3	4	Cockroaches, fleas, centipedes and mice
#7, Case 4	1	Cats and canary
#7, Case 6	1	Dogs
#8, Case 1	1	Dog
#8, Case 2	1	Mice
#10, Case 1	1	Rats
#14	1	Dog
#15, Case 1	1	Cows and poultry
#17	1	Rats
#18	1	Assorted pets, livestock and vermin
#27	2	Cat and dog who had no antibodies; mice
#37, Case 6	1	One cat who had no antibodies; another cat and a dog
Total	17 cases	

In only 9 cases (besides ours) were sick animal contacts described. In one (13) a pet puppy became blind and had fits and diarrhea during the third month of the mother's pregnancy. The father of afflicted twins (10, cases 2 and 3) handled dead rats, although the mother had no contact with animals. In the case of a 6 year old boy (6, case 1) the family had disposed of a sick half-grown cat which had frequent convulsions at about the time the boy became ill. A pet dog became "wild" and had to be disposed of during the eighth month of pregnancy with a baby afflicted with congenital toxoplasmosis (7, case 2). In the same series it was noted that during the two years before the mother bore the patient (case 5—a congenital case who was 11 years old at the time of the report), a pet cat had become ill and emaciated and was discarded, and a pet fox terrier had developed fits and was killed. Three acquired cases (37, cases 1, 2 and 3) had been in contact with the same sick cat in the period nine days to seven weeks before they became ill. Two of these children were clinically sick, the third was not. The cat's serum gave a positive dye test at a 1/100 dilution; the cat died soon after but was not autopsied.

The two recently reported cases of accidental laboratory infections (38) are not included in the 113 reviewed as they are not spontaneous in origin.

In addition to these examples there is a recent report from Germany (34) concerning the occurence of positive serum dye tests in 49 of 122 sick dogs. Of 38 persons in contact with 23 dogs whose sera contained antibodies, 23 had positive serologic reactions. The occurrence of clinical disease in these persons is not mentioned, and these are presumably asymptomatic infections.

DISCUSSION

Of the 36 cases specifically mentioning animal contacts, in only 8 are they denied. In 17 cases there were close contacts with some animal or vermin in the recent past. In 10 cases (including the present) there was definite contact with sick animals, although in 2 of these (twins) it was the father (who handled dead rats) and not the mother who had the contact (10). Actual proof that the sick animal had toxoplasmosis is limited to 3 cases, (37—cases 1, 2 and 3), although in our case the cat's symptoms and lesions are highly suggestive of a toxoplasmic infection.

The problem of tracing animal contacts in this disease is made unusually difficult by the following circumstances. First, if the animal were obviously ill it was usually disposed of, without examination, before the affected baby was born. Second, if serological tests are accurate indices, a large proportion of apparently healthy men and animals have been infected at some time. At least in animals, the organism may lie alive but latent in the tissues for long periods (39). Thirdly, casual contacts with pets and vermin are so common that they are easily overlooked. For these reasons we believe that more intensive investigation of animal contacts of known cases,

including serological testing of family pets, will yield useful information.

SUMMARY

1. The first reported case of congenital toxoplasmosis originating in Connecticut is discussed.

2. The mother was in contact with a sick cat during her pregnancy. The cat was autopsied soon after delivery of the affected baby and found to have small granulomata in the heart and brain.

3. In 113 cases of toxoplasmic infection described in the literature (including the present case) the subject of animal contacts was mentioned in 36. In 10 cases sick animal contacts were described, including 6 patients exposed to sick cats and 3 to sick dogs.

ADDENDUM

One year following the delivery of the afflicted baby, the mother delivered a healthy girl weighing 7 lbs. This baby is now six weeks old and thriving. No laboratory or x-ray studies have been made. The fundi are clear.

REFERENCES

1. Richter, R.: Meningo-encephalomyelitis neonatorum; anatomic report of a case; Arch Neurol. & Psychiat. 36:1085-1100, November 1936.

2. Wolf, A., and Cowen, D.: Granulomatous encephalomyelitis due to Encephalitozoon (encephalitozoic encephalomyelitis); new protozoan disease of man, Bull. Neurol. Inst. New York 6:306-371, August 1937.

3. Wolf, A., Cowen, D., and Paige, B. H.: Toxoplasmic encephalomyelitis; new case of granulomatous encephalomyelitis due to a protozoon, Am. J. Path. 15:657-694, November 1939.

4. Pinkerton, H., and Weinman, D.: Toxoplasma infection in man, Arch. Path. 30:374-392, July 1940.

5. Pinkerton, H., and Henderson, R. G.: Adult toxoplasmosis; previously unrecognized disease entity simulating typhus-spotted fever group, J. A. M. A. 116:807-814, March 1, 1941.

6. Sabin, A. B.: Toxoplasmic encephalitis in children, J. A. M. A. 116:801-807, March 1, 1941.

7. Cowen, D., Wolf, A., and Paige, B. H.: Toxoplasmic encephalomyelitis; clinical diagnosis of infantile or congenital toxoplasmosis; survival beyond infancy, Arch. Neurol. & Psychiat. 48:689-739, November 1942.

8. Paige, B. H., Cowen, D., and Wolf, A.: Toxoplasmic encephalomyelitis; further observations of infantile toxoplasmosis; intrauterine inception of disease; visceral manifestations, Am. J. Dis. Child 63:474-514, March 1942.

9. Steiner, G., and Kaump, D. H.: Infantile toxoplasmic encephalitis; report of case, J. Neuropath. & Exper. Neurol. 3:36-48, January 1944.

10. Zuelzer, W. W.: Infantile toxoplasmosis, with report of 3 new cases, including 2 in which patients were identical twins, Arch. Path. 38:1-19, July 1944.

11. Adams, F. H., Horns, R., and Eklund, C.: Toxoplasmosis in large Minnesota family, J. Pediat. 28:165-171, February 1946.

12. Callahan, W. P., Jr., Russell, W. O., and Smith, M. G.: Human toxoplasmosis; clinicopathologic study with presentation of 5 cases and review of literature, Medicine 25:343-397, December 1946.

13. Johnson, L. V.: Use of neutralizing antibody test in diagnosis of human toxoplasmic choroiditis, Arch. Opth. 36:677-684, December 1946.

14. Pratt-Thomas, H. R., and Cannon, W. H.: Systemic infantile toxoplasmosis, Am. J. Path. 22:779-795, July 1946.

15. Robertson, E. G.: Toxoplasmic encephalomyelitis, with report of 2 cases, M. J. Australia 2:449-452, September 28, 1946.

16. Syverton, J. T., and Slavin, H. B.: Human toxoplasmosis, J. A. M. A. 131:957-959, July 20, 1946.

17. Jacoby, N. M., and Sagorin, L.: Human toxoplasmosis in England, Lancet 254:2:926-927, December 11, 1948.

18. Kean, B. H., and Grocott, R. G.: Congenital toxoplasmosis, J. A. M. A. 136:104-108, January 10, 1948.

19. Sabin, A. B., and Feldman, H. A.: Dyes as microchemical indicators of a new immunity phenomenon affecting a protozoon parasite (toxoplasma), Science 108:660-663, December 10, 1948.

20. Schwarz, G. A., Rose, E. K., and Fry, W. E.: Toxoplasmic encephalomyelitis; clinical report of 6 cases, Pediatrics 1:478-494, April 1948.

21. Frenkel, J. K.: Pathogenesis, diagnosis and treatment of human toxoplasmosis, J. A. M. A. 140:369-377, May 28, 1949.

22. Hutchison, J. H.: Congenital toxoplasmosis; report of 2 cases, Arch. Dis. Childhood, 24:303-308, December 1949.

23. Mantz, F. A., Jr., Dailey, H. R., and Grocott, R. G.: Toxoplasmosis in Panama; report of 2 additional cases, Am. J. Trop. Med. 29:895-908, November 1949.

24. Sabin, A. B.: Complement fixation test in toxoplasmosis and persistence of antibody in human beings, Pediatrics 4:443-453, October 1949.

25. Campbell, A. M. G., and Clifton, F.: Adult toxoplasmosis in one family, Brain 73:281, September 1950.

26. Cowen, D., and Wolf, A.: Experimental congenital toxoplasmosis; I, The vagina as a portal of entry of toxoplasma in the mouse, J. Exper. Med. 92:393-430, October 1950.

27. Farquhar, H. G.: Congenital toxoplasmosis; report of 2 cases in twins, Lancet 259:562-563, November 18, 1950.

28. Freeman, P., and Pryor, H. B.: Toxoplasmosis in a 9 year old girl, J. Pediat. 36:365-369, March 1950.

29. Riley, I.D., and Arneil, G. C.: Toxoplasmosis complicated by chickenpox and smallpox; report of a case, Lancet 259:564, November 18, 1950.

30. Robson, J. T.: Human toxoplasmosis; family case study, Northwest Med. 49:42, January 1950.

31. Rodney, M. B., Mitchell, N., Redner, B., and Turin, R. D.: Infantile toxoplasmosis; report of case with autopsy, Pediatrics 5:649-663, April 1950.

32. Sabin, A. B.: Symposium: Toxoplasmosis; diagnosis and treatment, Tr. Am. Acad. Opth. 54:190-206, January-February 1950.

33. Wyllie, W. G., Fisher, H. J. W., and Cathie, L. A. B.: Congenital toxoplasmosis, Quart. J. Med. 19:57-66, January 1950.

34. Otten, E., Westphal, A., and Kajahn, E.: Epidemiology of toxoplasmosis; dogs as source of infection of human toxoplasmosis, Klin. Woch. 29:343-345, May 15, 1951.

35. Ratcliffe, H. L., and Worth, C. B.: Toxoplasmosis of captive wild birds and mammals, Am. J. Path. 27:655-667; July-August 1951.

36. Schrick, E.: Congenital toxoplasmosis; case report with autopsy findings, Permanente Found. M. Bull. 9:44, January 1951.

37. Siim, J. C.: Acquired toxoplasmosis, J. A. M. A. 147: 1641-1645, December 22, 1951.

38. Strom, J.: Toxoplasmosis due to laboratory infection in two adults, Act med. Scandinav. 139:fasc. 3, 244-252, 1951.

39. Weinman, D.: loc. cit.

THE DIABETIC MENU

Barnett Greenhouse, m.d., *New Haven*

The Author. *Attending Physician, Grace-New Haven Community Hospital, in charge of Metabolism Service and Diabetes Clinic, Grace Unit*

Important advances have been made in the detection and treatment of diabetes and in the philosophy of diabetic control. Diet has become more liberalized so that diabetics today are better fed than most people, and they are healthier and happier for it.

A most difficult approach to the diabetic diet is the prevailing effort to follow old racial food habits, or to revolve the diet around accustomed eating habits. The diabetic diet can otherwise be made very simple. The Diet Exchange System as sponsored by the American Diabetes Association aims to standardize and simplify the diabetic diet and is a step forward in the treatment of diabetes. With a bit of concentrated study the system can be readily learned by the physician and taught to the patient; and those who have already mastered it need go no further. But for the busy practitioner, however adequate this diet system is, it may be simplified even more. In evidence we present a practical "diabetic menu" which we have been using with much success in our clinic and in private practice for nearly thirty years.

Metabolism Diet

Protein 80
Fat 80
Carbohydrate 180 in 3rds c 9PM
Calories 1760
Available carbohydrate

MEAL / FOOD	APPROX. MEASURES	GMS.	PROT.	FAT	CARBO.
Breakfast:					
Fruit	1 serv.	*	1		12
Cereal	1 cup	30	3		24
Milk	½ cup	120	4	5	6
Egg	1	50	7	6	
Bread	1 sl.	25	2		13
Butter	1 sq.	5		4	
Cream	1 oz.	30	1	7	1
Tea or coffee					
Total			18	22	56
Dinner:					
Sandwich:					
Bread	2 sl.	50	5	1	26
Butter	1 sq.	5		4	
Meat, fish, cheese, or 2 eggs	2 oz.	60	14	10	
Salad vegetable	1 serv.	*			3
Fruit	1 serv.	*			12
Milk	½ cup	120	4	5	6
Tea or coffee					
Total			23	20	47

Prepared for presentation at the Diabetes Conferences of the George F. Baker (Joslin) Clinic, Boston, and the American Diabetes Association at the Chicago Session of the American Medical Association, June 9, 1952

From the Metabolism Service and Diabetes Clinic, Grace Unit, Grace-New Haven Community Hospital

Supper:					
Broth					
Meat, fish, cheese, or 3 eggs	3 oz.	90	21	15	
Potato	1 serv.	*	3		18
Cooked vegetable	1 serv.	*	3		9
Salad vegetable	1 serv.	*			3
Bread	1 sl.	25	2		13
Butter	3 sq.	15		12	
Fruit	1 serv.	*	1		12
Tea or coffee					
	Meat / Potato	Salad / Cooked vegetable			
	Bread	Fruit			
Total			30	27	55
9 P. M. feeding:					
Milk	1 cup	240	8	10	12
Saltines	3	12	1	1	9
Total			9	11	21
Daily total			80	80	179

Fruits and Vegetables Classification

Use only fresh fruits, cooked, stewed, waterpacked, or fruits especially canned with saccharine. Avoid all dried fruits. Do not use regularly canned fruits. Canned vegetables are allowed.

Salad Vegetables

Vegetables I 3% (as desired)

- Cabbage
- Celery
- Cucumbers
- Endive
- Lettuce
- Radishes
- Sauerkraut
- Tomatoes
- Tomato juice
- Vegetable juice
- Watercress

Cooked Vegetables

Vegetables I 3% 300 Gms. 1½ cup

- Asparagus
- Beans, green, wax and canned
- Beet greens
- Broccoli
- Cabbage
- Cauliflower
- Chard
- Endive
- Fennel
- Mustard Greens
- Okra (canned)
- Romaine
- Sauerkraut
- Spinach
- Squash, summer
- Tomatoes
- Swiss chard
- Turnip tops

Vegetables II 6% 150 Gms. ¾ cup

- Chives
- Dandelion greens
- Eggplant
- Kohlrabi
- Leeks
- Okra, fresh
- Peppers, green and red
- Pumpkin
- Pumpkin and squash (can)
- Squash, winter
- Soybeans
- Tomato puree (can)
- Turnips

Vegetables III 9% 100 Gms. ½ cup

- Beets
- Brussels sprouts
- Carrots
- Onions
- Peas
- Rutabagas

Vegetables V 15% 60 Gms. ¼ cup

- Parsnips
- Lima beans (canned)
- Artichokes

Potato or

Vegetables VI 18% 100 Gms. ½ cup

- Beans, home baked
- Beans, kidney (canned)
- Corn
- Potatoes
- Rice (cooked)
- Macaroni (cooked)
- Succotash (cooked)

Fruits II 6% 200 Gms. 1 cup

- Cantaloupe
- Muskmelon
- Watermelon

Fruits III 9% 135 Gms. ¾ cup

- Avacadoes
- Blackberries
- Cranberries
- Gooseberries
- Honeydew
- Grapefruit
- Lemons
- Limes
- Papayas
- Spanish melon
- Strawberries
- Tangerines

Fruits IV 12% 100 Gms. ½ cup

- Applesauce
- Apple juice
- Apricots
- Apricot nectar
- Orange
- Orange juice
- Grapefruit juice
- Peaches
- Peach nectar
- Pineapple
- Pineapple juice (fresh and canned)
- Fresh plums (not prunes)
- Raspberries, black and red

Fruits V 15% 80 Gms. ⅓ cup

- Apples
- Blueberries, fresh
- Grapes
- Kumquats
- Loganberries
- Mangoes
- Nectarines
- Pears
- Pear nectar

Fruits VI 18% 65 Gms. ¼ cup

- Bananas
- Cherries, sweet
- Figs, fresh
- Grape juice, unsweetened
- Persimmons, Jap.
- Pomegranates
- Prunes
- Prune juice

Measurements

1 cup = 8 ounces or 240 Gms. 1 ounce = 30 Gms.
1 ounce = 2 tablespoons 1 teaspoon = 5 Gms.

*Refer to Classification Sheet

Briefly, the breakfast menu calls for orange juice, cereal and milk, toast, egg and coffee; for lunch there is a sandwich, fruit and coffee; for supper, a "blue plate" of meat, salad, a cooked vegetable, and potato plus a slice of bread, fruit and tea; and milk and crackers on retiring. Thus, the diet resolves itself into a regulation breakfast, a sandwich lunch and a blue plate supper. A pint of milk is allowed for the day.

The chances for gross errors in the diet are greatly reduced since the breakfast and the sandwich lunch are popular meals and are easily followed. With two meals taken care of, the main meal is the only potential source of error. The pictured use of a blue plate will help materially to fix in the patient's mind the plan of this meal also.

Average normal portions are permitted and no sharp distinction is made between foods in the same category. Any cereal, dry or cooked, is allowed for breakfast in the same quantity. Any bread, toasted or not, in the regular cut ounce slice may be taken. All meats, fish, cheese and eggs are used interchangeably. Fruits and vegetables, because of the marked variation in carbohydrate content, are listed in servings adjusted to the proper portion.

The total intake of food must be kept constant from day to day. Weighing of the diet or at least use of household measures are, therefore, encouraged. The diet menu has been carefully calculated in grams using average normal servings. Food values are given to facilitate substitution and for use with any food list. For the less meticulous patient the diet list may be used merely as a menu suggesting the proper selection of food items and circumscribing the daily food intake in an effort to keep it constant.

The diet is a basic minimum and contains carbohydrate 180, protein 80, fat 80, but it can be adjusted to any level by additions at meal time or between meals. The carbohydrate may be increased simply by the addition of a slice of bread, or may be similarly decreased. The protein can be raised by increasing the meat portion or allowing more milk for children, and the total calories adjusted by the fat allowance.

The diet menu is flexible and lends itself to endless changes in variety. For example, the sandwich at noon can be made different every day in the week by using either meat, fish, cheese or egg. Similarly, the supper meal may be varied by a choice of any kind of meat or fish, and also by varying the vegetables and the fruit for desert. The diabetic menu serves as an outline suggesting staple food items which may be varied at will to suit the mood and the occasion.

The need for calculating the diabetic diet is only theoretical. From a practical standpoint a patient may at once be placed on this stock diet. Adjustments may be made according to the weight response. And since most diabetics are at first overweight, this basic diet is adequate and also serves as a good reducing diet, especially if fats are kept low.

With the use of insulin, and within the limits of the patient's weight and needs, it is not necessary to restrict but rather to circumscribe the diet. The aim should be to see how much food a patient may have rather than how little. While an overweight diabetic will need to reduce his food portions, a normal or underweight individual may enjoy bountiful servings. It is essential, however, that at whatever level the the diet is adjusted it be kept constant in order to balance the insulin requirement against it; for it is easier to vary the insulin than to make diet changes.

This simplification of the diabetic diet has for its virtue the fact that the average patient will at least know what his dietary pattern is and will more readily comply with it. Diet is basic; the simpler it can be made the better are the chances for diabetic control. The compromise has been accepted by the American Diabetes Association when it sponsored the Diet Exchange System.

SUMMARY

Diabetic diets are now less restricted and allow much freedom of choice of normal foods. The only restriction is in quantity. The diet can be adjusted to any desired level according to the physical needs of the patient but the quantity has to be the same every day; and to be sure of that the diabetic should weigh or measure his meals.

The author is indebted to Miss Amy Conwell, chief dietitian of the Grace Unit for her helpful cooperation and assistance for the past ten years in the planning and development of the diabetic menu.

NOCTURIA IN MALNUTRITION

SIDNEY VERNON, M.D., *Willimantic*

NOCTURIA may be attributed to different causes, including urinary obstruction, endocrine imbalance and infection. Diabetes mellitus or insipidus or a functional disorder may also be considered. Malnutrition should also be regarded as a cause.

Impressive evidence of nutritional nocturia was seen in a prisoner-of-war camp in World War II. Large numbers of men were affected showing a consistent clinical picture. This has been recorded in the European literature. Thaysen and Thaysen[1] report that famine disease shows cachexia, edema, diarrhea, polyuria and characteristic mental disturbances. Other observers[2,3] as far back as World War I have reported polyuria in starvation. Pereita[4] reports it in Madrid and others[5,6] report it in German concentration camps in World War II.

In October and November, 1942, in Cabanatuan (Luzon, Philippine Islands) droves of men were seen going to and from the latrine all night long to empty the bladder. Practically none went less than three times a night, some as many as 16 to 20 times. There was no pain but the urgency was strong. When the diet improved after the arrival of Red Cross packages at Christmas the symptom disappeared.

In 1943 in one prison enclosure containing Americians were also incarcerated about 20 Asiatics, probably Koreans. These men were emaciated in appearance and on heavy duty. After bedtime one could see two, three, or four of them at any time going to or from the latrine, thus spending much of the night on their feet because of the urgency of micturition.

Some American military personnel returning from the China-Burma-India theatre were encountered who had been stationed with Chinese troops and shared their diet. Some of these American soldiers had had nocturia, probably from malnutrition.

Desire to urinate results from the increasing volume and tone of the bladder. Increased secretion of urine produces frequency. Bladder tone may be increased by the irritability of infection and inflammation. Hormones may also affect bladder tone. Neurogenic symptoms may result from organic nerve disease and psychologic causes.

The urinary bladder of the infant is emptied by a spinal reflex.[7] The stimulus is muscle stretching, the response is detrusor contractions and rhythmic bladder contractions. The internal sphincter opens and then a powerful bladder contraction occurs, expelling the contents. As the child grows older, a suprasegmental reflex develops, putting the micturition reflex under the control of higher centers. If development is not adequate, contractions of the bladder wall remain uninhibited. Defective neural development, resulting in "uninhibited neurogenic bladder," may be the cause of the enuresis of school-age children. Involuntary uninhibited contractions are demonstrable in cystometric study in some cases of neurogenic bladder. This accounts for urinary frequency as seen in some personnel stationed aboard Navy destroyers.[8]

Endocrine effects on micturition from steroid hormones have been noted by Greenblatt,[9] who reports favorable effects with the use of testosterone pellets under the skin for the relief of nocturia in women. On the other hand, nocturia in elderly males is reported to be alleviated with oral diethylstilbestrol.[10] Since estrogenic hormone is said to lower the tone of musculature along the urinary tract,[11] it may act through lowering bladder irritability. (Among American prisoners of war in the Philippines an increased estrogen phase was noted in April, 1943, as evidenced by an epidemic of nodules of the male breast. At this time there was no nocturia and food had been improved for three months resulting from the arrival of the Christmas packages.)

MALNUTRITION AND URINE SECRETION

Rassuleo[12] states that 25 per cent of patients with pellagra show diabetes insipidus. Pellagra patients who have a concomitant beri-beri will show polyuria. Experience with nutritional nocturia points to thiamin deficiency. In experimental studies destruction of the supraoptic nucleus in the hypothalamus leads to diabetes insipidus. Clinically the control of urine secretion in diabetes insipidus depends on the use of pituitrin, elaborated by the posterior pituitary.

The supraoptic nucleus influences the posterior lobe to secrete an antidiuretic substance.[13] This substance accelerates tubular reabsorption in the kidney of the glomerular filtrate. Thiamin may be a building stone in the synthesis of antidiuretic substance in the body. But thiamin deficiency disease also leads to nerve pathology. Thiamin deficiency may disturb the supraoptic nucleus and its tract so that it fails to stimulate the posterior pituitary lobe. Such a disturbance is reversed by an adequate diet.

Beri-beri is characterized by involvement of the peripheral nerves, thiamin being the "antineuritic" vitamin. The occurrence of cerebral beri-beri[14] (Wernicke's encephalopathy with dementia and ocular disturbances) shows that tracts of the central nervous system may also be involved in this disease. Infantile beri-beri which occurs in nursing infants of malnourished mothers causes convulsions, added evidence of central nervous system involvement.

Thus, thiamin deficiency may cause dysfunction of intraspinal tracts, removing the inhibition of higher centers and reverting to an infant type of bladder reflex. Uninhibited bladder contractions may explain the imperious urge to urinate which is characteristic of starvation polyuria.

Thiamin deficiency is apparently involved in polyuria on either a hormonal or neurogenic basis. Increased nocturnal secretion may result from the influence of the recumbent posture on cerebral centers controlling the kidney. Also, postural hypotension occurs in starving individuals and may be associated with a higher glomerular filtration pressure with the normal blood pressure of recumbency.

The hungry may drink more water for the pleasure of momentary fullness of the stomach. Also, the diet consisting of soup and rice may have a higher water content. But, increased nocturnal urination occurs with famine even when total daily intake is not high and may persist in the person who shows starvation edema (wet beri-beri and hypoproteinemia). The increased urine has a normal composition with a lower specific gravity. Starvation polyuria is apparently a reversible diabetes insipidus-like state.

Prisoner-of-war patients with enuresis were treated by administering the available amount of thiamin in a single dose orally. A better effect was gotten with the limited supply, by a transient higher blood level of thiamin than by the effect of divided doses. Some improvement seemed to come from the better sphincteric control.

In the management of nocturnal frequency from any cause it is worthwhile to rule out deficiency by giving thiamin as a therapeutic test. The use of thiamin meets with favorable results in cases where obstruction and inflammation have been excluded. Ten to 25 mg. orally t.i.d. may be given daily.

SUMMARY

Occurrence of nocturia, a starvation symptom among American prisoners of war is described. A condition seen among large numbers of war prisoners may be seen sporadically in civilian practice. Neural factors and hormonal factors influencing urination and mechanisms of pathogenesis are discussed.

It is believed that thiamin deficiency is an important factor in this syndrome. Success with clinical use of thiamin supports this concept. Further clinical trial and laboratory study is desirable.

REFERENCES

1. Thaysen, E. H., and Thaysen, J. H.: Polyuria in Semistarvation. Papers dedicated to Dr. Poul Iversen, Rosenkilde and Bagger, Copenhagen 1949, p. 317.

2. Falta, W.: Ueber das Kriegsödem. Wiener Klin. Wochenschrift, 1917, 30:1637.

3. Knack, A. V., and Neumann, J.: Beiträge zur Oedemfrage. Deutsche Medical Wochenschrift, 1917, 43:901.

4. Pereita, M.: Neuropathien Infolge Mangelhafter Ernahrung. Arch. F. Psychiatrie, 1942, 114:611.

5. Gsell, O.: Untersuchungen uber Hungerodem. Helvet. Medical Acta, 1945, 12:511.

6. Adelsberger, L.: Medical Observations in Auschwitz Concentration Camp. Lancet, 1946, 1:317.

7. Konger, K. B.: Functional Urinary Frequency in the Soldier, Bulletin of the U. S. Army Medical Department, May 1947, 7:441.

8. MacGregor, C. A.: Urinary Frequency Among Personnel at Sea. U. S. Naval Medical Bulletin, May 1945, 44:1007.

9. Greenblatt, R. B.: Syndrome of Nocturnal Frequency Alleviated by Testosterone Proprionate. Journal of Clinical Endocrinology, May 1942, 2:325.

10. Klein, W., and Newman, B.: Oral Administration of Diethylstilbestrol for Prostatism. Archives of Surgery, May 1944, 48:381.

11. Bickers, W.: Post Menopausal Nocturia Treated With Testosterone Pellet. Urologic and Cutaneous Review, July 1945, 49:397.

12. Duncan, G. G.: Diseases of Metabolism, Second Edition, Saunders, Philadelphia, 1947, p. 681.

13. Hare, K., Hickey, R. C., and Hare, R. S.: Renal Secretion of Antidiuretic Substance. American Journal of Physiology, 1934, 134:240.

14. deWardener, H. E., and Lennox, B.: Cerebral Beri-beri (Wernicke's Encephalopathy) Lancet 1947, 1:11.

DOCTORS AND LAWYERS IN COURT

Louis H. Cohen, M.D., *New Haven*

The Author. *Chairman, Committee on Expert Medical Testimony, Connecticut State Medical Society*

What is expert medical testimony? What is wrong with it in its present usage? How can it be improved? What principles or practical knowledge should govern a physician when he finds himself in court to testify as an expert?

These questions were asked by the Connecticut State Medical Society and a Committee on Expert Medical Testimony was appointed in 1950 to seek some of the answers. The material obtained for this committee by direct interviews is presented in this paper for physicians and also for members of the legal profession who may be interested.

The problems arising out of the use of expert testimony have become more numerous and acute because of the increasing use of various technical experts in court. Medical knowledge forms the largest part of this growing volume of expert testimony. The large number of negligence actions, with the questions of liability and damages, have grown enormously. The wish by courts and lawyers to evaluate correctly the facts involved in litigation has brought a wider utilization of specialized medical knowledge. The psychiatrist finds himself increasingly involved in civil as well as criminal cases. Altogether, the law is using the doctor and his specialized knowledge more and more. Is the relationship an harmonious and effective one?

The common goal of securing justice can more easily be achieved when there is understanding and respect between the judge, the lawyer, and the doctor. Academically speaking, the definition of what constitutes evidence is entirely objective, but actually the forensic process is greatly affected by many psychological factors involved in the giving of testimony. The way the lawyer handles the doctor, his comprehension and sympathy, or lack of it, for the doctor's problems, influence the quality of the medical testimony he elicits, just as do the doctor's interest in and attitude towards legal problems. That there is a very unsatisfactory relationship between doctors and lawyers was assumed at the beginning of the investigation and was amply borne out by the interviews. Nevertheless, the patience and interest with which our questions were answered and the expressions of real good will in seeking a better solution of common problems gave us a feeling of encouragement. There is certainly no need for continued misunderstanding or of fear and resentment of one another when so many doctors and lawyers are aware of the problems and want to do something to solve them.

The interviews were quite informal. No written questionnaire was used but certain general questions were kept in mind. Anonymity was promised and illustrations were sought whenever they were available. The number of men interviewed was fairly small, 16 lawyers and 8 doctors, but it seemed a representative sampling. All the men interviewed had extensive courtroom experience with medico-legal problems. Though the generalization may not be quite fair, the lawyers seemed more cooperative than the doctors, more willing to give their time and to answer the questions thoughtfully. Neither group seemed happy with the other but both seemed anxious to improve the relationship.

COURTROOM APPEARANCE AS A WASTE OF TIME

The major cause of friction between doctors and lawyers is probably the doctors' unwillingness, even refusal, to appear in court. Most of the doctors considered court appearances to be a waste of time. As one doctor put it, "Lawyers seem to have all the time in the world and fail to understand the doctor's rush. There are all kinds of recesses and delays, a lot of palaver which seems to accomplish nothing and they seem to make no effort to push a case through expeditiously." The doctor's office schedule is much more exacting than the lawyer's. If he is told to appear in court at three o'clock, he expects to

be used at that time. One doctor gave an example of how irritating and costly court appearances have been to him. He was asked to appear on a Friday afternoon, cancelled all his appointments for that afternoon and at the appointed time started to leave for the court; to be caught by a telephone call advising him that he would not be needed until the following week. The doctor suggested that he was rather lucky in this instance, as on several previous occasions the call telling him of a delay in the proceedings came into his office after he had already departed for the court.

Most lawyers were aware of the difficulties the doctor faces in being called, and they were usually apologetic about the delays and the loss of time. But apologies were difficult for the doctors to accept good naturedly. After all, several hours of probably unrecompensed time had been lost, and the penalty of later office hours that day and delayed house calls seemed too high a price to pay. As one doctor put it, "All we can be sure of is that we won't be needed in court before ten, between one and two, and after five!" One lawyer maintained that "the doctors are inclined to punish us for the defects of the trial schedule." The lawyers had to admit that the courts are very overcrowded and it would entail an enormous expenditure to solve the scheduling problem at the present time. Recognizing this, lawyers, for the most part, stated that they did whatever was in their power to advise the doctor of the progress in the case and to be as definite as they could about the time he would be needed in court.

One doctor who appears in court quite frequently has adapted himself to the uncertainties involved by handling his appearances in court as if they were emergencies. He tells the lawyer to give him an approximate time for his appearance and then asks to be called half an hour before he is expected to go on the stand. When he is called he leaves his office with the explanation to his patients that he "has been called out on an emergency," and that they will be given new appointments at their earliest convenience. He said that his patients are sympathetic and recognize that the doctor is giving the same consideration to another patient which they would wish to have offered to them. The doctor finds that his acceptance of the fact that the lawyer's client is also his patient and deserves to be treated as one saves him time and money.

It sometimes happens that the doctor is out on an "emergency" at the time he is needed in court. This is a perfectly plausible excuse but many lawyers feel it is often dishonestly used. They would prefer to be told at the beginning that the doctor will not testify rather than have him accept the patient grudgingly and then fail to show up in court. A lawyer recalled a case in which the doctor was scheduled to appear in court at twelve o'clock. When he failed to do so, a mistrial was declared with the attendant waste of time which this meant. Lawyers feel that doctors should regard their occasional courtroom appearances as part of their professional obligation to their patients and this kind of irresponsibility on the doctor's part was to them unforgiveable.

Many doctors commended lawyers and judges for cooperating, after they had come to court, by allowing them to testify at once. Some doctors felt that it was the lawyer's obligation to call the court's attention to the doctor's presence if he was unrecognized. A few doctors have found that lawyers will accept written testimony in the rare cases where there is no controversy about the medical testimony.

In some cases the refusal of doctors to testify has necessitated the use of the subpoena. The doctors, as a rule, resented the threat of the subpoena but those who were case hardened stated that they pocketed the 60 cents, and proceeded to call the lawyer to state that they would be available when needed. The lawyers, with some exceptions, resented the need to resort to the subpoena, especially since it relieves the doctor of the responsibility of acting as an expert witness if he refuses to do so. The doctors were rarely entirely clear as to the purpose of the subpoena, mainly because few of them had been informed by the lawyer as to his need to use it. Most lawyers insisted they used the subpoena rarely but a deputy sheriff who was questioned reported a surprisingly frequent resort to it. His experience reinforces the idea, popular among some doctors, that they are called into court, not in the interest of the patient or to facilitate justice but to advance the lawyer's personal interest.

REMUNERATION

Closely allied with the problem of time was the problem of remuneration. Most doctors felt that they are underpaid for their court appearances since they suffer various losses which the lawyer does not seem to take into consideration. Besides the examination or examinations of the litigant, there is the preparing of the medical report, the study of the relevant medical literature, the cancelling of ap-

pointments, (frequently on more than one occasion) to be ready for the court appearance. All this may be useless preparation because a settlement out of court may be made at any time. And finally, there is the exasperating effort, frequently unavailing, which must subsequently be dedicated to collecting fees.

Several doctors complained bitterly about the necessity of sending bill after bill to lawyers. In many instances, lawyers did not bother even to acknowledge the bills. Often the doctor did not know that a case had been settled before trial because the lawyer had not bothered to send him any word about it. Whether or not it is true that lawyers take out their own fees before paying their clients, but leave it to the clients to pay, or not to pay, the doctor's bills, the majority of doctors felt this was the case. They maintained that medical testimony should be considered a part of the lawyer's expenses, and paying for it should be his responsibility.

The physicians were rather grim about the tremendous fees lawyers collect when they work on a contingency basis. They said that when such cases hinge on medical testimony, as they often do, their bills for fifty or one hundred dollars will be protested, while the lawyer may collect many thousands of dollars. When the case is lost or the amount awarded small and the lawyer explains that he has not been paid either, doctors are again dissatisfied. Most of them asserted that they wanted neither excessive nor niggardly fees but fair compensation for their work, whatever the outcome. They did not wish to accept a gamble on the chance of enormous profit (which the doctor does not receive, anyhow) but wanted a reasonable fee to be guaranteed by the lawyer for his use of their time and skill. One doctor sued for non-payment of a seventy-five dollar bill, out of annoyance at the lawyer's nonchalant disregard of his bill. Several doctors claim that they refuse to take cases from lawyers who have not paid them in previous instances or ever to direct a patient who may need a lawyer to their office.

Lawyers complained about the problem of fees as vociferously as the doctors did. Many of them felt that medical charges are exorbitant and could not understand why they should be so high. Even when the client has not collected enough from his suit to pay the court expenses (and few litigants are ever completely satisfied), the doctors would not consent to a cut in fee. Since the lawyer is in charge of the funds, he can always guarantee his own share though often he does not do so. (Unfortunately, most of the doctors felt that the lawyers took their own fees first, not last, or not at all). The refusals by doctors to cut fees and a tendency to overcharge for services in court led many lawyers to the conclusion that a large number of doctors are interested only in "grabbing money" and that they have little or no interest in the client, who is also the doctor's patient, or in seeing justice administered. This attitude on the part of the lawyers was considered sanctimonious, hypocritical or worse, by all the doctors interviewed.

Several lawyers regarded the doctors' unwillingness to appear in court because of the doubt about suitable remuneration with some disgust. They felt that doctors, on the whole, have less civic interest and sense of obligation than any other professional group. They maintained that as attorneys they accept indigence cases as a duty but that doctors considered court work in such cases an infringement of their rights rather than as an obligation. They felt that doctors can afford to be more liberal in the adjustment of court fees. The relatively small proportion of the doctor's time taken up in courtroom work is for the most part lucrative, they said, and that part of it which is not paid for should be considered a normal civic responsibility.

INADEQUATE MEDICAL PREPARATION

The reluctance of the doctor to testify leads, from the lawyer's point of view, to additional complaints. Even after the doctor had agreed to come to court, he was not willing to make adequate preparation. A medical report is absolutely necessary for the lawyer so that he can plan his case before going into court. Many lawyers insisted that it was impossible to get adequate medical reports from some doctors and that it was sometimes impossible to get any report at all.

The lawyer wants reports he can understand. The medical implications of his case must be clear to him. A report (wrung out of the doctor by continued pressure, phone calls, etc.) which is condensed on a 3 by 2 card is not very enlightening to the layman, which is what the lawyer is, of course. If the condensation is "in Latin," as lawyers say it usually is, and must be translated with a medical dictionary in one hand, it is of small value. Medical dictionaries are written for doctors, not for lawyers, so that the lawyer finds himself still pretty much in

the dark. If he calls the doctor for further explanation the lawyer states he may be rebuffed, given a terse reply or at best, very little help.

The medical report is obviously of extreme importance to the lawyer. No matter how well the doctor understands the case, the lawyer is helpless unless he has a clear picture of the medical situation. He must ask the questions which will best elicit the medical testimony and the lawyer's confusion and bewilderment can scarcely produce intelligent questions. Practically speaking, the doctor does himself as well as the patient a bad turn by sending a poor report, for his fee often depends on the outcome of the case. Morally speaking, he certainly owes it to everyone concerned to write an intelligible and helpful report, once he has agreed to come in on the case.

The pretrial conference between lawyer and doctor would be an ideal arrangement to iron out these difficulties, but the doctor's tight schedule, some lawyers said, seems to preclude this possibility. On the other hand, no doctor reported that he had ever been asked to attend a pretrial conference in any negligence action. The compensation courts are a conspicuous exception.

FEAR OR DISTASTE OF CROSS EXAMINATION

Inadequate preparation results not only in the badly written report but in too little thought about the case in all its medical aspects. The lawyers suggested that the doctor's reluctance to testify in court grows out of his fear of cross examination. They believe that if the doctor had spent the requisite amount of time and thought on the case, he would have no reason for such anxiety. One lawyer claimed that he had never seen a doctor's testimony seriously shaken by cross examination unless the doctor was poorly prepared, ill at ease and hesitant. Such a situation may be quite damaging to his case. The implication here seemed to be that the lawyers want their medical witnesses to show and maintain an air of certainty and poise under the actual or potential barrage of cross examination.

Some doctors who dislike to testify in court attributed their distaste to the "unsavory" courtroom atmosphere. One doctor referred to a case in which the lawyer knew that his client's injury was "obviously his own fault." The case was taken to court for its nuisance value and the doctor felt that he was being dragged into an unethical situation. Many doctors feel that the stigma attached to such legal work inevitably becomes attached to them. They fear that court appearances may put them a little outside the pale of medical ethics, and that their reputation among their colleagues may suffer. The term "court doctor" was considered opprobrious, and every doctor interviewed stated he would dislike to be called one.

DIFFICULTY WITH THE PRINCIPLE OF REASONABLE PROBABILITY

The methods used in medicine and in law to arrive at the truth are very different. In law it is only necessary that the doctor give an opinion on the probability, not the certainty. When the subject of reasonable probability is approached in court, the doctor begins to hedge. He will not state in the courtroom things about which he may have little doubt privately. He is too inclined to think of himself as a pure scientist and to think of legal proof in the same terms as he does of scientific proof. Unless a statement can be proven conclusively, he rarely admits in court that in his opinion it is so.

Because of this many of the lawyers interviewed accused the doctors of being downright cowardly in the giving of testimony. They believe that most doctors are afraid of disagreeing with their colleagues over medical issues or of being shaken on cross examination with resultant public embarrassment. One lawyer suggested that "doctors lead too sheltered a life." In their private offices they remain above reproach. In the courtroom, subject to criticism and controversy over their opinions, they are acutely unhappy and reluctant to make positive statements. When a lawyer asks a doctor whether exposure to iron dust can be reasonably supposed to cause silicosis and the doctor refuses to admit it because he is not absolutely sure, he shows how completely he fails to understand the legal approach.

One of the frustrating experiences reported by doctors was to have to wait to be asked the right, i.e., the important or relevant, medical questions. The lawyer often did not know what questions to ask. This was especially true in cases where the hypothetical question came into the picture. Often it is too poorly formulated to be of any value because it is framed by the lawyer who simply doesn't know the data which are relevant to include, becomes flustered by the objections which are inevitably made, attempts to reformulate the question, often with even less success than the original one, all this while the doctor sits silently in the witness box

waiting for the jousting to stop and while the jury becomes bored or amused or exasperated. One doctor suggested that if the hypothetical question is to be used, it might be better for it to be formulated by the doctor himself and given to the attorney to get into evidence beforehand and then to ask, an idea which is certainly unorthodox and conceivably is unethical.

Doctors may be too sensitive about their prestige and the prestige of their profession. In one case which the lawyer felt substantiated this conclusion, a man came into the compensation court with a doctor who claimed that he suffered from a herniated disc. The insurance company doctor said that the man was a faker. To the lawyer's amazement, within a short time the two doctors agreed in their diagnosis. Did this sudden *volte face* result from the doctors' fear of admitting publicly that doctors frequently do have perfectly honest disagreements about diagnoses? The frequent failure to understand that the lawyer is only seeking to elicit reasonably probable proof rather than scientifically indisputable fact in a given situation is only one aspect of the doctor's failure to understand the legal point of view.

LIMITS OF OPINION-EVIDENCE

As a witness the doctor must not introduce material which he has not himself observed. Sometimes the doctor submits as evidence statements which patients have made, but which describe things the doctor did not see. He may allow himself to be influenced by statements which patients make to him, not realizing that they may be motivated in these statements by a wish to influence the doctor's testimony at the impending trial. For the most part, patients are quite honest in describing the circumstances of their injuries and their symptoms to doctors. Doctors are not on the lookout for the deceit which, unfortunately, litigation sometimes produces.

Often the doctor questions the patient about the nature of an accident and when he makes his statement in court he includes much of these data. Since the doctor is not permitted to consider problems of negligence, such evidence is immediately ruled out. However, the jury has heard the testimony, and it cannot be so easily ruled out of the jury's mind. In one instance a doctor wrote in his report that the patient fell down the stairs because there was no light in the hall. The patient had told him this and he saw no reason to doubt it, not realizing that it was for the court, not for him, to decide whether this statement was true. The medical expert sometimes forgets that he is an opinion-witness. There is often a fine line between consideration of damages and liability and the doctor needs some preparation and training to draw it so that his testimony may achieve the highest possible degree of validity and acceptance.

Through their ignorance of legal procedure, doctors sometimes give out confidential information. They should know that the patient's record can be testified to only with the patient's consent. Several cases were reported which led to the loss of a suit and unnecessary damage to patients because such confidential information was given out. If the doctor would make the effort to familiarize himself with what is permissible and what is not, he would not find himself intimidated into the disclosure of privileged information.

The doctor's failure to understand the legal point of view is no more frustrating to the lawyer than is the courtroom atmosphere to the doctor when it seems, as it frequently does, to seek to discredit rather than to confirm the truth. One doctor complained of the frequent attempt, not to misinterpret or even to distort, but to completely discredit honest testimony. He had appeared in a case with his usual type of note card on the patient, several lines of abbreviated notes summarizing three interviews. He had also written a much more detailed report for the attorney. When he went to court, the opposing lawyer, in an attempt to upset his testimony, questioned whether it was possible for anyone to remember all that occurred in the full report from the few lines on the note card. This kind of maneuvering gives many doctors a distaste for courtroom battles.

Another doctor spoke bitterly of an accident case in which two people in the same car had been injured. He testified that both patients had suffered similar injuries. The lawyer suggested sarcastically that a situation in which two people suffered exactly the same injuries was just short of miraculous. The implication seemed to be that the doctor was capable of making only one diagnosis. The doctor had acted perfectly competently and in good faith and said that from a medical point of view the similarity of the injuries was easy to understand.

A psychiatrist recalled a similar instance of being discredited. He had been asked in court how long he had known the patient. The psychiatrist on the

other side had "treated the patient at an institution for a year and a half" while this psychiatrist who was reporting the incident had spent an hour and a half with the patient making an intensive examination on which to base his diagnosis. The institution doctor might easily "have walked by the patient every morning for a year and a half and not have done a damn thing for him," was the doctor's angry comment and his honest indignation at the opposing lawyer's belittling questions caused the judge to end questions of that sort.

The psychiatrists' disillusionment with the uses and abuses of their testimony is particularly acute in divorce actions. When a lawyer asks, "Isn't this really a case of a mother's unselfish love and devotion?" about a woman whom the psychiatrist has characterized as "dangerously overprotective," the doctor is irritated at the playing up of sentimental aspects of the case which quite distort the truth. This stretching and taking out of context of psychiatric evidence makes the doctor feel very uncomfortable. One psychiatrist said, "In some of these divorce cases, the psychiatrist is just being used conveniently to help air dirty linen."

MEDICAL MANNERS IN THE GIVING OF TESTIMONY

The doctor needs to remember that the lawyer is a fish out of water when he is involved in a medical situation just as the doctor is when faced by the intricacies of legal "fact," admissable testimony, and the bewilderments of legal language generally. Giving good testimony is an art which very few doctors have mastered. They are inclined to forget when they come to court that they are not addressing the medical society. As one lawyer expressed it, "Sometimes people would like to know what the doctor is talking about. Matters would be helped if he would speak English." There was a widespread complaint on the part of the lawyers about the tendency to rely on medical terminology to carry the weight of medical evidence. Many lawyers were of the opinion that the doctor, feeling lost in the courtroom, attempts to regain his sense of security by using words which no one understands. Other lawyers felt doctors use technical language deliberately to show their erudition. The most experienced and, consequently, the most tolerant lawyers, seeing the bewilderments which the forensically inexperienced doctor faces, simply suggested that with more preparation and more experience the doctor would learn to communicate with laymen.

It would be impractical and stupid of the doctor to come to court unless he hopes to be helpful to the side he represents. Yet, if his evidence is unintelligible, it is not only useless, it may easily be damaging. Lawyers say that the average juror does not understand the words "prognosis" or "prior," let alone the more abstruse medical terms. Juries tend to get bored with evidence they do not understand, and to react unfavorably to people who confuse them. When such a situation prevails, the lawyer must ask the doctor to restate, to explain, to clarify, while time is being used up and antagonism is growing. Since time is at least as important to the doctor as to anyone else in the courtroom, he is doing himself a real disservice when he fails to give his testimony in the simplest, most intelligible form.

Doctors complained with as much resentment about legal jargon as did lawyers about medical terminology. Especially in the psychiatric field there was considerable difficulty along this line. A psychiatrist may say, with complete accuracy, of a deluded woman who has, let us say, murdered someone, that she "knows the difference between right and wrong" and that "she is perfectly sure she was right in her deed." The legal definitions are completely at variance with the medical concepts involved here, and make intelligible testimony very difficult to offer. If the doctor asserts that she knows right from wrong, he is qualifying her to stand trial. Being offered no legal terms in which he can explain his position, he may feel he must perjure himself, say the patient does not know right from wrong, and so save the insane person from the unjust trial situation.

MEDICAL PARTISANSHIP

Another large area of complaint stemmed from what the lawyer labeled "partisanship" on the part of doctors. The degree of bias varies. A few cases of criminal bias, to the point of perjury, were quoted, but such flagrant examples, most lawyers agreed, are extremely rare. Many lawyers felt strongly, and quoted illustrative cases to substantiate their point, that doctors who work for insurance companies are strongly influenced in their testimony by the source of their income. They felt that no doctor should do too much work for an insurance company because it makes him a poor witness in court. The doctor whose report is markedly different from other reports submitted by other doctors is immediately suspected of bias if he is

known to do considerable work for the company. More subtle, but disturbing to both lawyers and doctors, is the opinion which is too conservative. Such "pussyfooting," as the lawyers termed it, may stem from a conscientious effort on the doctor's part to remain objective. Actually, since there is usually some leeway in medical interpretation, it is enormously difficult to achieve objectivity. In an effort to lean over backward, the doctor may find himself being completely noncommittal and consequently useless to the side which has engaged him.

Bias may take even more subtle tones when the degree of damage is to be determined. For example, in a compensation case recently two insurance company doctors agreed that loss of vision amounted to 33 per cent. Two doctors appearing for the litigant placed the loss at 83 per cent. Both sets of doctors were probably quite honest in their estimates, but the disparity in their judgments made it apparent that they were being influenced, even though unconsciously, by external factors. Any doctor whose financial interests are involved in a case, whether it means that he gets his bill paid if his patient wins his case or that the insurance company wins through his testimony, is in a difficult psychological situation. It would seem fairly obvious, however, that it is the doctor's duty to give his services in these legal situations when they are so necessary, always bearing in mind the need for the use of utmost skill and objectivity.

The lawyers complained that doctors sometimes labor under the misconception that they are supposed to hide unpleasant truths. On the contrary, lawyers want to know the whole truth so they can prepare for it, even if the findings tend to favor the other side. The reputable lawyer does not want exaggeration or distortion of the facts, and appreciates the doctor's straightforward reports. In this way he can come into court, if he chooses to bring the case to trial at all, with full knowledge of the medical facts, and of the probable diverse expert opinions with which he may have to deal. Doctors make poor lawyers was the consensus of all the lawyers interviewed, and should not attempt in their opinions to slant the medical facts in any way. Every lawyer admitted contempt for all those doctors who had ever attempted to "help" him in this manner.

SUMMARY AND RECOMMENDATIONS

Assuming that the data presented here are a fair sample and cross section of medical and legal opinion of expert medical testimony, the following recommendations for an amelioration of an admittedly difficult and complex problem may be put forth. These are based on the opinions offered by the men interviewed in this study, but also include some ideas which are my own.

The recommendations made by the doctors may be summarized as follows:

1. The waste of time entailed by courtroom work could be minimized by attorneys who would utilize an assistant or a secretary to keep in touch with the doctor who expects to testify so that he could be called just in time to go on the stand. This appears, to the doctor at least, to be a simple enough procedure if the attorney would cooperate.

2. The knotty question of remuneration would be resolved by the inclusion of the medical expert's fee in the lawyer's costs. Ideally, the doctor should have no financial dealings with the patient or client before or after the trial. The doctor's fee would be determined beforehand and calculated on a fair per hour basis. It would include all time in court, whether spent in testifying or not. The amount determined would be independent of the amount of damages requested or awarded.

3. The use of the subpoena should be resorted to only for doctors whose recalcitrance about appearing in court appears to make this procedure necessary. Cases of abuse of the subpoena might be reported to the State Medical Society which in turn might turn the complaint over to the Grievance Committee of the State Bar Association.

4. The problems and potential embarrassments of cross examination might be solved by instruction to attorneys in the peculiar psychology of the medical witness. The courts generally recognize the need to permit the expert to give his opinion, and the basis for it, in his own way. On the other hand, the medical expert must never lose sight of the fact that his opinions are a legitimate target for attack and re-evaluation, that he need feel no embarrassment to change his opinion if new evidence demands it and that no personal significance is to be attached to the criticism of his opinion.

Recommendations made by the lawyers consist essentially of the following:

1. The doctor should recognize his personal and civic obligation to appear in court in order to assist in the administration of justice.

2. The doctor should recognize that, as an expert, he is expected to give opinion-evidence and nothing more. Such opinions should be understood within the framework of the doctrine of reasonable probability rather than as a statement of irrefutable scientific proof. He must have an appreciation of the limits of his testimony, particularly as it refers to confidential and privileged information.

3. It is expected that the expert witness has come to court well prepared with respect to the factual basis of his opinions. His records should be sufficiently complete so that the court may inspect them on request. His language in his reports and in his testimony should be as free of medical vernacular as possible and his attitude should be patient and helpful in making his statements understandable to the court and jury.

4. The doctor must school himself to refrain in his testimony from any actual advocacy or any semblance of it. He should recognize that the very fact that he is testifying at the request of one side or the other makes his opinions suspect. He must be most careful and scrupulous in the evaluation of all the medical facts, avoid sentimentality and dramatics and at the same time be free to admit that new or other facts may lead him to a different opinion.

Some further suggestions may also be made. The desirability of a nonpartisan panel of medical experts is a plan which merits fuller evaluation. This would include the establishment of fees, set by the court, which conceivably might come out of a fund established by a "tax" on the damages involved.

There appears to be a real need for instruction and discussion between doctors and lawyers in the evaluation of common courtroom problems. This could be done in both a formal and informal manner by a joint committee of the medical society and the bar association. Out of such discussion might well emerge some concrete proposals for the amelioration of the present unfortunate state of medico-legal affairs as it is reflected in the antagonism of doctors and lawyers in their common courtroom problems.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Fairfield, Wednesday, October 1

Wee Burn Country Club, Darien

Golf: 1:00 p. m. Business meeting: 4:30 p. m.

Dinner: 6:30 p. m.

Speaker: John M. Gleason, Chief of Police of Greenwich

Subject: RECENT EXPERIENCES IN POLICE MISSION TO GERMANY

New London, Thursday, October 2

Uncas-on-Thames Hospital, Norwich

Speaker: William A. Cooper, M.D., Professor of Surgery at Cornell

Subject: CANCER OF STOMACH

Litchfield, Tuesday, October 7

Torrington Country Club, Goshen

Time of meeting and speaker to be announced

Middlesex, Thursday, October 9

Griswold Inn, Essex

Time of meeting and speaker to be announced

Windham, Thursday, October 16

Place and speaker to be announced

Tolland, Tuesday, October 21

Place and speaker to be announced

New Haven, Thursday, October 23

Place and speaker to be announced

Hartford, Tuesday, October 28

Chippanee Country Club, Bristol

Golf: 12:00 p. m. Business meeting: 4:30 p. m.

Social hour: 6:30 p. m. Dinner 7:00 p. m.

Speaker: Hon. Arthur F. Ells, former Justice, Connecticut Supreme Court of Errors

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief* - Hartford
Herbert Thoms, *Literary Editor* New Haven
Harold S. Burr - - - New Haven
Frank Stafford Jones - - - Hartford
Marshall C. Pease - - - Ridgefield
E. Clair Rankin - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

For Your Information

The recognition of encroachment by government upon the rights of constituent states and citizens of those states has concerned the people of this republic since its beginning and beyond. As citizens in a colonial empire the spirit of liberty for the individual was deep in their hearts, so deep as to lead to the famous Declaration and the American Revolution. Today, as in those historic times many of the same sinister forces are present, influences which threaten our liberty of thought and action. Operating under various guises there are among us those with political power who believe that the extension of certain federal controls are indispensable for the security and welfare of our citizens. The doctor, as a citizen and more especially as a physician, has far more than an academic interest in these things, for it is a wider control of his professional activity that is a primary objective of those who are engaged in such sinister activities.

In November, the doctor, as a citizen, has the privilege of casting his vote for candidates for public office. Those elected become our legislators and make or unmake our laws. In this they have a heavy responsibility to their constituents and to the political party which they represent. The voters have a right and a duty to know what candidates stand for personally and in relation to the platforms of their party.

In preparing this issue of the Journal we have sought to obtain such information from many of our Connecticut aspirants to political office. This should be helpful, not only in determining the doctor's course of action at the polls but also it may vicariously assist others who may look to him as a source of information. There can be no question in any doctor's mind that his liberty as a physician has been in danger before and that it will be threatened again. A very great part of his protection rests with himself, for he must be worthy of his high responsibilities and his profession must maintain, within itself, certain freedoms which all men will recognize as a part of their own liberty.

Hospital Problems and Doctors

Dr. Thomas P. Murdock, in his address* before the Catholic Hospital Association on the Relation of Hospital Administration, Nursing Staff and Medical Staff, recognizes many problems relative to hospitals and their administration and gives timely and sage advice for aid in their solution. He emphasizes that lack of mutual understanding in these groups is a major cause in many disagreements and recommends that the establishment of "a committee for the improvement of the Care of the Patient would help a great deal in understanding and even in solving these problems," and says further, "We will not be doing our full duty to the patient until we have set up, in each hospital, such a committee bringing this advancement, and I feel it is an advancement, directly to the patient. This hospital committee, made up of representatives of these three groups would go far in the solution of all these problems."

Dr. Murdock points out the important necessity of physicians who use hospitals to become familiar

*J. A. M. A., Vol. 149, No. 14, p. 1304, August 2, 1952

with the problems of administration, also emphasized by Dr. Gunnar Gunderson of La Crosse, Wisconsin, a fellow member with Dr. Murdock on the Board of Trustees, AMA. Speaking before the American Surgical Trade Association at Chicago, June 5, 1952, he stated, "The financial problems of an institution, in which a physician does his professional work, are definitely of importance to him and to the professional staff, and the proper consideration must be given to these problems, if the hospital is to work efficiently and remain the workshop of the physicians, and without proper facilities the services rendered to the public are in jeopardy and these public services are the all-important function of both hospital and staff." Dr. Murdock emphasizes the importance to the life of a hospital of willingness on the part of physicians to give lectures to nurses, aid in teaching programs, library and other hospital functions, activities outside of the immediate care of patients, but definitely contributing to it.

The Clinical Case Report

There is no phase of medical writing more useful or of higher reader interest than the clinical case report interestingly presented. It is true that the report of a single case simply limited to clinical findings may not be of significant interest if many similar cases are already in print. This fact, however, should not be a deterrent to writing up such a case if it embodies a discussion which, in itself, may be thought provoking and of educational value.

Too many men feel that they should not write unless they can contribute something of major importance to medical knowledge. To them this means only writing often long and exhaustive study of a subject. Such contribution, obviously, is of highest importance and essential in medical research. Even such reports, however, if they are to attract wide reading, must embrace writing skill.

The Clinical Case Report occupies an important, if peculiar role, in medical literature. When well presented, it creates high reader interest because of its relation, potential or actual, to the clinical problems of the reader himself. This should be considered by the writer and in most instances such reporting should be short and pointed. Only significant features should be recorded and, if physical examination and laboratory tests reveal nothing abnormal, they should be curtailed. If literature is to be cited, only the most recent and important papers should be mentioned. The Clinical Case Report need not be a difficult task, it can be an interesting writing experience if the writer keeps the reader in mind, not forgetting that to lose him is to create a critic.

In the staff conferences of many hospitals within our State where cases are presented, consideration should be given to the advantages of a wider audience. Chiefs of staffs and of services can be helpful in suggesting such writing experience to staff members in such reporting. Editorial advice and assistance from the JOURNAL is always available.

Tinted Optical Glasses

The Joint Committee of Industrial Ophthalmology of the American Medical Association and the American Academy of Ophthalmology and Otolaryngology expresses alarm about the number of claims made for tinted optical glasses and the number of people using them for all kind of purposes, in a statement of a subcommittee, entitled Tinted Optical Media appearing in the National Safety News. The general comments found in the report are of significant interest and read:

In considering the use of glasses to reduce overhead brightness either indoors or out, it is to be remembered that a visor or broad-brimmed hat is a most effective shield, and will frequently obviate the necessity for sunglasses.

This Sub-Committee condemns the use of any type of "night-driving lens." Any such lens, whether colored, reflecting or polarizing, reduces the total light transmitted to the eye and renders the task of seeing at night more difficult. Similarly, it condemns the use of colored windshields (which may prove a hazard at night) or the promotion of removal filtering or polarizing shields as a useful aid in night driving.

As applied to the general civilian population, this Sub-Committee endorses the thesis that sunglasses should be worn only when the intensity of light produces discomfort, and that the penalty for their wear otherwise is the reduction of the individual's tolerance to bright light. Unless indicated by definite ocular pathologic processes, the habitual use of sunglasses indoors is most objectionable.

It is emphasized that no commercially marketed sunglass is sufficiently dense to permit direct gaze at the sun. Much denser filters are required for safe view of a solar eclipse.

With respect to the mildly tinted lenses designed for constant wear, it is recognized that the more dense of this group are useful in the presence of photophobia due to pathologic conditions. In the

absence of pathology those more dense tints should not be prescribed for constant wear. The total light transmission of the lighter tints differs so little from that of crown glass that they are not considered effective filters in pathologic states. The Sub-Committee has no objection to the use of the very mildly tinted lenses if the patient desires them and can afford the additional cost. It is emphasized, however, that we do not agree that they offer physiologic advantage over crown glass for use under fluorescent lighting or other lighting situations.

The Sub-Committee is aware of the investigations which have shown that prolonged exposure to bright sunlight impairs night vision subsequently. This factor is of extreme importance in certain military situations but of very questionable importance in civilian life. The motorist viewing the road ahead under headlights is dependent upon photopic vision; and we are not convinced that photopic vision is appreciably improved by the use of sunglasses. Rather, we believe that the inadvertent wear of sunglasses at dusk constitutes a far greater hazard in driving on the highways than any possible decrement in vision at low levels of illumination.

The Hospital Library

"The value of a library is not in the amount and variety of material it contains, in the spaciousness of its quarters or in the cost of its maintenance, but rather in the use to which it is put." So say Dr. Paul D. Rosahn and Sadie M. Karpman writing on the Medical Library of a Non-University General Hospital.* These words recall the story of a sightseer in New Haven, surveying the great book tower on High Street, who asked a man about to enter, "Is this the Yale Library?" The man, who happened to be the librarian replied "No, the library is inside."

Dr. Rosahn and Miss Karpman describe, in considerable detail, the library development which has taken place in the New Britain General Hospital. They show what the possibilities are for similar developments elsewhere and the experience there will be helpful to those interested in such enterprises. These authors pay tribute to the Yale Medical Library, the Hartford Medical Society and the New Britain Institute Library, to mention some Connecticut institutions which have been helpful in the program. It is apparent from reading their report that high praise is also due to the fine spirit of "dedicated" staff members. This is seen in their closing words, "But above and beyond the need for money, there must be the deep conviction by medical staff and by administration, that no other single use of funds will so measurably improve the medical standards of the institution. Such a conviction does not arise de novo. One or more dedicated souls, members of the staff, must, by discussion, persuasion, exhortation, and conciliation, strive to engender this concept in both staff and administration. Once this has been accomplished, the library is secure."

*J. A. M. A., Vol. 149, No. 14, p. 1335, August 2, 1952

Socialism By Treaty

The American Medical Association has warned that adoption of the social security minimum standards convention of 1952 poses the danger of socialized medicine by treaty within the United States. This is a warning that should command careful attention. The entire proposition should be explored, item by item, before we are committed to purchase.

The United States has a four-member delegation to the International Labor Conference at Geneva, Switzerland. This delegation stands accused of following radical labor viewpoints on all proposals. It would be somewhat surprising were this not so.

This covenant, like most of its kind, has a quick surface appeal. Its apparent objectives may be those all men desire. However, surface appeal is not enough. It must be certain that each individual proposal, each single item is sound, practical and just.

It has been largely due to the efforts of the AMA, and other like thinkers, that we have escaped the web of socialized medicine by domestic legislation, so skillfully woven by Oscar Ewing and his Fair Deal following and their White House masters.

The victory in health freedom thus apparently won for the American people must not now be lost. It would appear that the socialized medicine schemers have not surrendered.

One approach failing, they are now trying another. As the AMA points out, socialized medicine by treaty now appears a greater threat than socialism by domestic legislation.

We do not want either.

If we are to escape we must clearly realize that a treaty, once ratified and in force in the United States, automatically becomes a part of municipal law. We must therefore be alert to bar the entrance of socialism by any such back door route.

From New Haven Register

Anesthesiology, A Challenge

This is the title of the Chairman's Address given by Dr. Stevens J. Martin of Hartford before the Section on Anesthesiology at the AMA meeting on June 11, and appearing in the Journal of August 23, 1952. It is a scholarly presentation and deals with many questions pertinent to developments in that field in our own State. A goal, which Dr. Martin says should demand steady aim, is that there be at least one competent anesthesiologist serving each hospital in which anesthetics are administered, a situation in which we are making good progress toward fulfillment. Dr. Martin points that advantages in such a recommendation extend beyond the professional field to that of public relations.

The question of private practice of anesthesia on a fee-for-service basis shows illumination by Dr. Martin. According to a reliable survey experience, close to 80 per cent of anesthesiologists are engaged in this type of practice. He raises the question, "if the national trend is in favor of the policy of private fee-for-service anesthesia, then is it irreconcilable that 20 per cent of our members do not conform? Is their interpretation of the national policy on economics and ethics in the practice of anesthesia based on local, regional, or other factors, not yet clarified or known? Or is it the dogmatic and persistent apposition of the American Hospital Association that makes conformity difficult?"

Dr. Martin's survey of problems now facing anesthesiology as a specialty warrants wide consideration.

Tuberculosis in Connecticut

Spoken of as the most complete and up-to-date story of what Connecticut is doing in tuberculosis, the July-August issue of the *Connecticut Tuberculosis Association Bulletin* contains the complete set of papers presented at the Tuberculosis Section of the New England Health Institute, June 18, at the University of Connecticut. It shows a significant record of accomplishment for our State which has been recognized as a leader in the battle against this disease since the establishment half a century ago of one of the first sanatoria in this country at Gaylord Farm.

In spite of the great developments in treatment however, it has been calculated, based on survey experiences, that at the present time there are approximately 9,000 unknown cases of tuberculosis in Connecticut, one-third of which have active disease. The importance of extension of x-ray surveys is emphasized, particularly in older men and in patients admitted to general hospitals. The x-ray is the best single means of discovering chest disease in the early stages.

As shown by this report we have an excellent program in Connecticut and greatest credit must go to the multitude of devoted workers in the various voluntary and official health and welfare agencies. The Bulletin is to be congratulated upon its timely and comprehensive presentation.

Cash Sickness Benefits For Two Out of Three Connecticut Workers

A governor's committee appointed for the purpose of drafting an off-the-job sickness and disability insurance bill to be submitted to the next regular session of the General Assembly has reported that two out of three Connecticut workers are now receiving some cash benefits when they are unable to work through illness or injury received off the job. The survey which covered 94.6 per cent of workers indicates that 67.1 per cent of all workers surveyed have some form of cash sickness protection. The hospital and school groups have highest coverage, 86.7 per cent protected under wage continuation plans. Lowest protection is in the service group 20.4 per cent.

The percentage of workers protected in each size group increases with the size of firms in each group. Among the largest firms, the 500 to 999 group protects 83.7 per cent and the 1,000 employees and over group 92.6 per cent. Data as of February 15, 1952 based on schedules received through May 16, 1952 shows the type of protection for Connecticut workers to be, insurance 46.9 per cent, wage continuation 15.8 per cent, union welfare and other 4.4 per cent, not covered 32.9 per cent. Copies of the complete study may be obtained from Connecticut Bureau of Labor Statistics, 92 Farmington Avenue, Hartford.

A Successful Congress

The 1952 Connecticut Clinical Congress proved to be a highly successful and happy event. The registrations numbered 819, the highest figure since the war, the previous high in 1948 being 793. The change in location to the Medical School for all sessions proved the wisdom of the Arrangements Committee. Of the 819 who registered, 598 repre-

sented paid admissions, the remainder being students and house officers who were guests of the Congress. A pleasing event of the Congress was the dinner given complimentary for Dean Vernon W. Lippard, who assumes his duties at Yale on January 1, 1953. The success of the Congress as a joint enterprise of the Society and the Medical School should foretell increasing opportunities for usefulness in such cooperation.

A United Effort

Joining forces for community action is one of the main goals of medical public relations. Everywhere in America medical associations are activating community service programs. These are positive programs to meet community needs. They are directed by county and local medical organizations.

In line with these efforts, the Connecticut State Medical Society has joined with the Connecticut State Dental Association in providing a Conference Committee with five representatives from each society. The purpose of this committee is to consider projects of mutual interest—educational, prophylactic, and economic, and to activate appropriate committees for positive action. Currently the question of fluoridation of public water supplies received favorable consideration. A more active program of school health and industrial hygiene is under consideration.

The medical profession has much to learn from the dental profession. Optimum health can only be maintained through the cooperative efforts of both professions. It is time for the medical profession to lend an attentive ear to the dentists as frequently the dentists have given heed to the doctors. It should be mutually pleasant and beneficial to include dental subjects in our winter programs and invite the Dental Association to provide suitable speakers. Such cooperation will improve public relations and strengthen the respect of each Society for the other.

Intern Eligibility and Recruitment for Connecticut Hospitals

Over fifty representatives of Connecticut institutions met in New Haven on August 28 to discuss problems relating to intern placement in Connecticut Hospitals. The meeting was sponsored by the Connecticut State Medical Society, President Edward J. Whalen presiding, and Dr. John D. Booth, president of the Connecticut Examining Board, acting as moderator. Previous to the general discussion the following program was presented: 1. Legal and Regulatory Aspects of Intern Eligibility, Dr. Creighton Barker, secretary, Connecticut Medical Examining Board; 2. The Responsibilities of the State Department of Health, Dr. Stanley H. Osborn, Commissioner of Health; 3. The Process of Approval of Medical Schools, Dr. Louis P. Hastings, member of Connecticut Medical Examining Board; 4. Observations by a Hospital Intern Committee, Dr. William J. Lahey, director of education, St. Francis Hospital, Hartford; 5. Observations by a Hospital Administrator, Howard S. Pfirman, administrator, Middlesex Hospital, Middletown.

The general discussion was extended and revealed a wide interest and concern in the intern situation as it applies to Connecticut hospitals. It was shown that out of 127 available internships, aside from those in two large general hospitals, 62 or less than half are filled at the present time. By unanimous vote it was decided that further deliberations of this subject would be useful and in order to carry this out the chair was directed to appoint a steering committee from names placed in nomination from the floor. The following will serve as this committee, Dr. O. J. Bizzozero, Waterbury; Dr. F. J. Braceland, Hartford; Dr. V. A. Cacace, Bridgeport; Dr. J. W. Colbert, New Haven; Dr. F. W. Finn, Greenwich; Dr. I. S. Geeter, Hartford; Mr. R. J. Hancock, New London; Dr. W. J. Lahey, Hartford; Dr. H. Levine, New Britain; Dr. D. O'Connor, New Haven; Mr. H. Pfirman, Middletown; Dr. J. M. Wool, New London.

The following Connecticut institutions were represented at the meeting: St. Francis Hospital, Hartford; Grace-New Haven Community Hospital; Meriden Hospital; Hospital of St. Raphael, New Haven; Lawrence Memorial Hospital, New London; Stamford Hospital; Norwalk Hospital; Danbury Hospital; St. Joseph's Hospitals, Stamford; Manchester Hospital; McCook Hospital, Hartford; Gaylord Farm Association, Wallingford; Institute of Living, Hartford; Middlesex Hospital, Middletown; Waterbury Hospital; Mt. Sinai Hospital, Hartford; Hartford Hospital; Norwich State Hospital; St. Vincent's Hospital, Bridgeport; Bridgeport Hospital; W. W. Backus Hospital, Norwich; New Britain General Hospital; Greenwich Hospital. Also present were official representatives of the following: American Medical Association, Connecticut State Medical Society, Connecticut Medical Examining Board, Connecticut State Department of Health.

PROGRESS IN CLINICAL MEDICINE

EYE EMERGENCIES AND THE GENERAL PRACTITIONER

R. M. Fasanella, M.D., *New Haven*

The Author. *Assistant Clinical Professor of Ophthalmology, Yale University School of Medicine*

It can be readily understood how the diagnosis and extent of an eye injury and its treatment can puzzle the practitioner when some cases are difficult for the eye specialist. A striking example of the therapeutic quandary to even the ophthalmologist is the story of the medical officer overseas, a professor of ophthalmology and a prominent authority in his field, who had conclusively proved that the time honored use of atropine, a dilator, in hyphemia (blood in the anterior chamber of the eye) was wrong. He felt that constriction of the pupil with a drug such as pilocarpine hastened the absorption of blood because the iris and its greater surface with the use of constrictors sped absorption. This work had been substantiated by many animal eyes. However, when confronted with hyphemia in the eye of a world reknowned British General in World War II, this same doctor fell back to the time honored atropine.

Many good ophthalmologists feel that the middle course, absolute rest, flat in bed, with occlusion and no local eye medications, is the best way to meet the many complications that can ensue in hyphemia. This the practitioner can certainly do until he can get the aid of an ophthalmologist.

As in every phase of medicine routine procedures, especially in diagnosis, is very helpful. Perhaps the greatest single guide to the nature and extent of an eye injury is an acuity. If the patient can see well, the eye is in all probability not seriously involved. Glasses, if worn, should be used. If ordinarily worn and broken or lost, a pencil hole in a piece of paper serving as a pinhole can often readily show just about how well a patient can see. If an acuity chart is not present, ordinary newspaper headlines and a comparison of the patient's vision and that of the examiner will serve as a good clue as to the status of the patient's vision. If the patient has hemorrhage in the injured eye or a cataract, counting fingers, hand motion, light perception and light projection in that order, act as a record of acuity. Light projection in addition, serves to give a clue as to the status of the retina. For example, a light held at hand's length and perceived by the eye in question in both upper and lower quadrants is some indication that perhaps the retina is intact.

If one wants more accurate data (not usually required in a traumatic case) as to the status of the macula in hyphemia or cataract, the ability to name accurately a red light as red or a blue light as blue is presumptive evidence of a good macula since it is chiefly the function of the macula to discern colors. The ability to see two pocket lights at one meter as two when separated, about an inch or less, is also good presumptive evidence that the macula is uninjured.

FINGER TENSION

Finger palpation of the eyes through the lids is more important in determining a soft eye than a hard one. Even experienced ophthalmologists do not rely on finger tension for an increased ocular tension without other clues such as symptoms and findings such as steaminess of the cornea, etc. Even the novice should be able to tell the feel of a soft eye following an injury. What, by history, was a good eye previously, and even when the anterior portion looks normal, should immediately suggest a penetration posteriorly if soft to palpation with the fingers.

FIELD OF VISION

A field of vision does not require elaborate equipment such as a perimeter or a tangent screen. Confrontation is simple but requires that the two hands of the examiner be free. Simpler and perhaps as effective, is to have the patient close one eye, look at the nose of the examiner as the center of fixation and then ask the patient if he can in one glance, at

arms length, see the examiner's hair, both ears and chin. One or even both hands of the examiner can be free to hold open swollen or ecchymotic lids. This test takes but a minute but is very useful.

INSPECTION

In the inspection a routine is rewarding. One proceeds from the outer to the inner components. First, the lids should be examined. If the lids are torn, these should be sewn with fine sutures either layer by layer from the inside to the outside and from below to the lid edge if in the lower lid. A second general method is through and through, suturing with the outer stitches sewn over fairly heavy rubber tubing to prevent buckling of the tarsal plate. The lid border and the nasolacrimal passageway require special consideration. To prevent a "V" defect or notching postoperatively, the lid edge must at the time of the operation, be exaggerated in just the opposite direction, i.e., an "A" or tent effect must be obtained. If there is a "through and through" tear involving the nasolacrimal duct, the chances of this recannulizing without special technical approach are nil. The most important single suture is (1) through the puncta; (2) the tear in the lateral side; (3) through the tear on the medial side; (4) and above the sac.

Next in the examination come the conjunctiva and cornea. Unseen tears or abrasions in either are often brought out by staining with fluorescein 2 per cent, washed with normal saline. The contrasting yellow-green color of the fluorescein in the area of an abrasion or tear can often explain an eye pain.

If examination is difficult, a drop of a surface anesthesia such as 0.5 per cent pontocaine will make a difficult job easier.

In the bulbar conjunctiva, two types of hemorrhage must be distinguished. The "intracranial" and the "local" types of hemorrhage. The intracranial type of hemorrhage represents a bleeding along the floor of the brain leaking through the optic foramina along the deep tissues of the eye called Tenon's capsule. This type of hemorrhage is serious, indicating serious intracranial damage. It is a delayed type of hemorrhage, not seen immediately following injury and dissects its way forward so that it is seen hours following a head injury. It is seen in the lower portion of the eye and progresses with its apex moving forward. No clear border can be seen in the fornix of the eye if the eye is turned upward. The hemorrhage is purplish in appearance and is not moveable as it is deep. In contrast, the purely local type of hemorrhage, often seen with a "black eye," is an immediate reaction, red in the initial stages, moveable and in any quadrant of the conjunctiva. If an apex is seen, it usually points backward where a clear border of white conjunctiva is usually to be found in the fornix. This type of hemorrhage has a good prognosis as a rule, with or without treatment.

FOREIGN BODIES

In the case of surface foreign bodies, asking the patient before the use of a local anesthesia such as pontocaine 0.5 per cent, where he feels it, often gives a good clue. If the foreign body suspected is glass, flooding the eye with 2 per cent fluorescein and looking for the glass in the yellow fluorescein before washing it with saline, is often rewarding. If the foreign body is not found, washing the fluorescein may show the source of the pain is a scratch or abrasion. Turning the upper lid should be included in the routine.

After examination of the cornea, hyphemia, the presence of an anterior chamber, the comparative depth, iridodenesis ("dancing" or tremulous iris) irododialysis (a tear of the iris in its periphery) to be suspected in the flattened area if a non-round pupil must be looked for. In iridodenesis suspect a dislocated or an absent lens (aphakia).

If the examiner has or uses an ophthalmoscope, the lens and vitreous must be examined. In the vitreous the examiner must look for hemorrhage. Hemorrhage behind the vitreous and in front of the retina is called pre-retinal or subhyaloid hemorrhage. This type of hemorrhage is purplish in color and because of gravity, often assumes a boat shape appearance, the top being flat and the bottom round to oval. Hemorrhage or edema in the area of the macula is common in blows to the eye proper. Because of the distribution of the fibers here, the appearance of hemorrhage or edema is often star shaped.

PAPILLEDEMIA, OPTIC NEURITIS AND PSEUDONEURIITS

Again, for the doctor who uses the ophthalmoscope, papilledema or "choked disc," must be sought. The serious differential here is optic neuritis and "pseudoneuritis." "Pseudoneuritis" is as the name implies, a simulated neuritis. Optic neuritis can be further subdivided into the intraocular and the retrobulbar types. In "choked disk" or papilledema, there is swelling of the nerve head with few or no inflammatory signs; no disturbance of vision at the onset; there may be early enlargement of the blind

spots; loss of vision and secondary optic atrophy may be found later. Papilledema is usually bilateral and is to be suspected if the swelling is greater than two diopters.

In intraocular optic neuritis there is moderate swelling of one nerve head with inflammatory signs. The swelling is as a rule less than two diopters. There is considerable disturbance of vision at the onset and a field, if one can be obtained, will show a "caecocentral scotoma," i.e., one extending from the blind spot to the point of fixation; secondary atrophy may appear later.

In retrobulbar neuritis there is no swelling of the nerve head. "The patient sees nothing and the doctor sees nothing." Temporal atrophy of the optic nerve may develop later.

In pseudoneuritis there is a simulated type of swelling of the disc in a hyperoptic (far sighted) individual with good vision.

BURNS

Burns of the eyes with the exception of ultraviolet burns, do not as a rule pose diagnostic problems but are therapeutic problems. With the single exception of lime burns where the individual particles must be dug out, the simplest and most effective treatment is copious irrigation with plain water or normal saline immediately. Precious time must not be lost in trying to find a neutralizing agent. If the patient is an adult the best thing he can do is to stick his head into a basin of water and open his eyes. Ultraviolet burns are the same regardless of whether caused by an ultraviolet lamp, exposure at the beach or a welder's burn. The history can sometimes be vague or lacking unless looked for carefully. An example of this is one of a carpet store manager who was led in by his wife after midnight, unable to open his lids with severe photophobia and pain, emphatically denied any exposure to ultraviolet. Staining with 2 per cent aqueous mercurochrome and the use of the slit lamp, revealed the typical multiple stippled areas of the cornea seen in these cases. Given an anesthetic ointment incorporating epinephrine, the patient returned home and after a night's rest recalled having substituted for a friend in an inn where for six hours he had been in and out of a glass washing machine which used ultraviolet to add an extra factor of sterilization to the beer and cocktail glasses. For months the other employees, with the exception of one, who unknowingly was protected by his glasses, complained of sore eye. This case shares the etiology on ultraviolet burn of the buttocks from ultraviolet toilet seats now used in service stations on the parkways.

ACUTE LOSS OF VISION

Acute loss of vision must make one consider hysteria, occlusion of the central retinal artery or vein, massive vitreous hemorrhage of separation of the retina. Hysteria may be suspected if there is absence of organic findings. The ophthalmoscope in occlusion of the central retinal artery shows typically a "cherry red spot" in the macular area because of the surrounding edema. In occlusion of the central vein, the typical "sunburst of hemorrhage" of every description are noted. Massive vitreous hemorrhage is not difficult to diagnose. Separation of the retina is seldom sudden and is either accompanied by a history of multiple specks prior to the separation or the history of a severe blow.

Vigorous massage of the eye or vasodilators may occasionally be of help in occlusion of the central artery. Early keratocentesis (within 4 hours) by an ophthalmologist may also be effective. The use of the anticoagulants may be of some help in occlusion of a central retinal vein. Retinal separation is purely a problem for the specialist.

ACUTE CONJUNCTIVITIS, IRITIS AND GLAUCOMA (PRIMARY)

The differential diagnosis of acute conjunctivitis, iritis and primary glaucoma is still one of the most troublesome diagnostic problems in ophthalmology. It is permissible for the practitioner to treat conjunctivitis with a drug such as aureomycin, locally, if he is sure of his diagnosis. Iritis and glaucoma, however, are problems for the ophthalmologist. Even in the hands of a skilled ophthalmologist, eyes can be lost if these problems come to him late.

Pain in acute conjunctivitis is almost nil. It is moderate in acute iritis and very severe in acute glaucoma. There is no tenderness in conjunctivitis but there is marked tenderness in acute iritis and glaucoma. Injection is superficial in conjunctivitis and deep ciliary in iritis and glaucoma. The tension is normal in conjunctivitis, usually normal or low in acute iritis and high in glaucoma. The media is clear in conjunctivitis, shows opacities on the cornea in iritis, and steaminess of the cornea in acute glaucoma. The secretion is mucopurulent in acute conjunctivitis but watery in acute iritis and glaucoma. The vision is good in conjunctivitis, fair in acute iritis and poor in glaucoma. The onset is gradual in

conjunctivitis, gradual in iritis and sudden in glaucoma. Systemic complications are not present in conjunctivitis, few in iritis and common in acute glaucoma often with prostration and vomiting. Certainly in case of doubt, the patient should be sent to the ophthalmologist as early as possible.

BIBLIOGRAPHY

May, C. H.: "Manual of the Diseases of the Eye," published by William Wood & Co. 1950.

Gifford, S.: "Gifford's Textbook of Ophthalmology," published by W. B. Saunders Company, Philadelphia and London. 1947.

Fasanella, R. M.: "An Unexpected Case of Ultraviolet Burn of the Eyes Received In An Unusual Manner." (To be published in the American Journal of Ophthalmology.)

Callahan, A: "Foreign Bodies of the Eye," J. A. M. A. 142:249 January 28, 1950.

Cogan, D. G.: "Lesions of the Eye from Radiant Energy," J. A. M. A. 142-145 January 21, 1950.

Grant, W. M.: "Chemical Burns of the Eye," J. A. M. A. 142-152 January 21, 1950.

Kronenberg, B:. "A Case of Intralenticular Foreign Body with Early Removal." Am J. Ophth. 27:1427, December, 1944.

Marshall, D.: "Lacerations of the Eye," J. A. M. A. 142:246 January 28, 1950.

Payne, B. F.: "Ocular Contusions in National Emergencies," J. A. M. A. 142-243 January 28, 1950.

Pritikin, R. I.: "Essentials of Ophthalmology," published by J. B. Lippincott Company, Philadelphia, London, Montreal. 1950.

Stone, W.: "Ocular Injuries in the Armed Forces," J. A. M. A. 142:151 January 21, 1950.

Vail, D.: "Discussion. Symposium on Ocular Injuries," J. A. M. A. 142:253 January 28, 1950.

LETTER TO THE EDITOR

Connecticut Blue Cross and Anesthesia
A Reply to Dr. Garofalo et al

Dr. Garofalo et al in his article on anesthesia appearing in the August issue of this JOURNAL, stated that, in his hospital anesthesia was recently changed from a hospital service (covered by Blue Cross) to a medical service (not covered by Blue Cross). He implies that Blue Cross is meddling with anesthesia, then damns it for not being concerned with his problem of improving its quality.

With the inconsistencies of anesthesia practice as between the various medical staffs and hospitals throughout the State, Dr. Garofalo points out that the anesthesia situation today is highly confusing to the public and to the medical profession. With his statement on the subject of confusion, much of the public agrees. The public, unlike Dr. Garofalo, does not however take its issue with Blue Cross, but, rather, with its source.

The purpose of this statement is to avoid further confusion which could well be caused by Dr. Garofalo's article.

Dr. Garofalo's statements regarding the policy of Connecticut Blue Cross on anesthesia are entirely incorrect. Blue Cross policy, which is carried out in its contract with the subscriber, descriptive literature and otherwise, is covered in the following statement which is given to those of our subscribers who inquire:

"The benefits of Connecticut Blue Cross pertain only to hospital services rendered and billed by the hospital in which the patient receives treatment. Connecticut Blue Cross does not and can not cover the services of any private physician. This is stated in our Rules and Regulations and descriptive folder.

"Accordingly, anesthesia service is included in the basic service benefits covered by Connecticut Blue Cross only when provided by the hospital as a hospital service and included in the hospital's bill. Whether or not anesthesia is provided by the hospital is under the direct control of the hospital and its medical staff. This is entirely outside the control of Connecticut Blue Cross.

"Certain hospitals have discontinued providing anesthesia service. In these hospitals, anesthesia is being provided and billed by private physicians in a manner similar to the private services of the surgeon or other private physicians.

"Connecticut Blue Cross does not and can not provide payment for the services of private physician anesthesiologists."

During its entire fifteen years of operation, as at present, Connecticut Blue Cross has followed this policy and taken great pains to avoid taking any position whatsoever as to the basis on which anesthesia should be rendered. We feel this is strictly a medical-hospital matter, and one in which Blue Cross has no right or desire to intervene. Dr. Garofalo et al to the contrary.

Robert Parnall,
General Manager

THE PRESIDENT'S PAGE

Malcolm MacEachern has stated that hospitals should be deeply concerned with the proposed use of the Medical Audit as a means of measuring the efficiency and results of hospital care. He believes that a medical audit is of far greater importance than a financial audit since financial deficits eventually can be met but medical deficiencies may cost lives and loss of health which can never be retrieved. Not all doctors will agree that this analogy is a happy one since the static figures of hospital bookkeeping can in no way be related to the end results of the skill and artistry exhibited by physicians.

Medical auditing should be an overall evaluation of the administrative as well as the professional consideration given to the patient during a stay in the hospital. It is not a check on the activities of individual physicians. However, it is a method of uncovering flagrant errors of omission or commission. Such errors the hospital and the professional staff must meet with courage and decision.

In hospitals where a Medical Audit is conducted the survey among other items will compare preoperative diagnosis with final diagnosis; compare surgical diagnoses with tissue findings; consider the treatment adopted against the indications as noted and judge of the sufficiency of the investigations ordered: e.g., pathological, cardiographic, biochemical, etc. In the larger hospital the Medical Audit will be carried out on a departmental basis, perhaps by a professional auditor. In the small hospital it will, of necessity, be an internal audit pursued by a group from the professional staff of the hospital.

Hospitals have become big and strong and have, for the most part, adopted a more or less uniform method of hospital bookkeeping, departmental cost analysis and frequent financial audits. It is surprising that more hospitals have not insisted on an audit of their prime activity, the care of their sick inmates. It will be well for the professional staff of the hospitals to inaugurate such an audit if for no other reason than to save themselves the embarrassment of being confronted with such an audit which otherwise may be ordered by the hospital trustees or some other lay group.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

SPECIAL COMMITTEE TO CONFER ON MEDICAL EDUCATION

At the request of the Governor's Commission to Study the Facilities for Medical and Allied Education in Connecticut, the President and Chairman of the Council of the Society have appointed the following committee to confer with the Commission of which Mr. Howard Houston is the Chairman.

Edward J. Whalen, Hartford, President

Harry C. Knight, Middletown
John C. Leonard, Hartford
D. Olan Meeker, Riverside
Clifford D. Moore, Stamford
Charles T. Schechtman, New Britain
Paul W. Vestal, New Haven

PRESIDENT'S COMMITTEE HONORS PHYSICIAN

Dr. Henry H. Kessler, orthopedic surgeon and medical director of the Kessler Institute for Rehabilitation at West Orange, N. J., is the recipient of the first Physician's Award of the President's Committee on Employment of the Physically Handicapped. This announcement was made by President Truman at a meeting of The President's Committee on September 4, at which your secretary, who is a member of this Committee, was in attendance. The award, an illuminated scroll, signed by the President, will be presented at a meeting in the near future. Dr. Kessler was a speaker at the Clinical Congress held here in September.

Duties of the Committees

STANDING COMMITTEES

COMMITTEE ON ARRANGEMENTS

Article X, Section 3, Par. 1 of the By-Laws of the Society provides:

The Committee on Arrangements shall be appointed by the component county association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting place of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the executive secretary for publication in the program. The report of the Committee to Survey the Annual Meeting adopted by the House of Delegates on May 1, 1951 recommended that the chairman and one other member of the Committee on Arrangements, for the meeting in the year immediately preceding, serve with the Committee on Arrangements from the association in the county where the annual meeting is to be held. It was further recommended by the Committee to Survey the Annual Meeting, and adopted, that the Local Committee on Arrangements should be responsible for the arrangement of the program for the annual dinner of the Society.

COMMITTEE ON POSTGRADUATE EDUCATION

Article X, Section 3, Par. 2 of the By-Laws of the Society provides:

The Nominating Committee shall appoint to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purpose of the Committee shall be to plan and make available programs of postgraduate education for members of the Society, to arrange and conduct the annual Clinical Congress of the Society, and to cooperate with University and other agencies within the state for the extension of postgraduate education of physicians.

EDITORIAL BOARD OF THE JOURNAL

Article X, Section 3, Par. 3 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates each year an Editorial Board of the JOURNAL to consist of five members, and nominate the Chairman of the Board who shall serve as Editor-in-Chief of the JOURNAL. The Editor-in-Chief shall be a member of the Council. In addition to the Board so nominated, the President of the Society shall serve as an ex officio member with all rights and privileges of other members during the term of his office.

The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

COMMITTEE ON HONORARY MEMBERS AND DEGREES

Article X, Section 3, Par. 4 of the By-Laws of the Society provides:

The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

COMMITTEE ON HOSPITALS

Article X, Section 3, Par. 5 of the By-Laws of the Society provides:

The Nominating Committee shall nominate annually to the House of Delegates, a Committee on Hospitals to consist of not less than six members, and shall nominate the chairman thereof. This Committee shall pursue the continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

COMMITTEE ON INDUSTRIAL HEALTH

Article X, Section 3, Par. 6 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the chairman thereof. The function of this Committee shall be to inquire into health in industry for the purpose of making the information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

COMMITTEE ON MEDICAL EDUCATION AND LICENSURE

Article X, Section 3, Par. 7 of the By-Laws of the Society provides:

At each annual meeting the Nominating Committee shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the executive secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the president of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the president shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the president of that Board as elected by its members shall be the chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

PROGRAM COMMITTEE

Article X, Section 3, Par. 8 of the By-Laws of the Society provides:

The Program Committee shall consist of three members, one member of which shall be nominated annually by the Nominating Committee for election by the House of Delegates for a term of three years. The chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange a scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

COMMITTEE ON PUBLIC HEALTH

Article X, Section 3, Par. 9 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine, not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration, desirable legal enactments to promote public health within the State.

COMMITTEE ON STATE LEGISLATION

Article X, Section 3, Par. 10 of the By-Laws of the Society provides:

Before the 15th of January of each year, the secretary of each county association, acting on behalf of the association, shall forward to the Executive Secretary of the Society, the name of a member of the county association who is recommended to the Nominating Committee for nomination as a member of the Committee on State Legislation,

In addition to these eight members, the Committee shall include the Delegates to the American Medical Association and the Executive Secretary who shall serve as the executive officer of the Committee. The Chairman of the Committee shall be designated by the Nominating Committee. The function of this Committee shall be to review and advise the members of the Society concerning proposed state legislation pertaining to the public health, welfare and the practice of medicine. The Committee shall, as occasion arises, draft and have introduced into the General Assembly of this State, appropriate legislation for improving medical care and the public health within the state, advise the Society's legislative agent concerning the opinion of the Society on pending legislation, and supervise and direct the Society's program in the state legislative field.

COMMITTEE ON PUBLIC RELATIONS

Article X, Section 3, Par. 11 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio, and cooperate with other committees of the Society in a program of public relations.

CANCER COORDINATING COMMITTEE

Article X, Section 3, Par. 12 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Cancer Coordinating Committee. The membership of this Committee shall be not less than seven and not more than nine members and shall at all times include the President of the Connecticut Cancer Society, the Chairman of the Connecticut Association of Tumor Clinics and a representative of the State Department of Health. The purpose of this Committee shall be to coordinate and integrate the efforts of the various agencies concerned with the study, prevention and treatment of cancer in Connecticut.

COMMITTEE ON PROFESSIONAL RELATIONS

Article X, Section 3, Par. 13 of the By-Laws of the Society provides:

At its semi-annual meeting in 1950, each component county association shall elect a past-president of the Association to serve on a State Committee on Professional Relations. The members so elected from the association in the counties of Hartford, New London, Windham and Middlesex shall serve until the annual meeting of these associations in 1951, at which time the Hartford, New London, Windham and Middlesex county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years, and such election shall be bi-annually thereafter. The members so elected from the associations in the counties of New Haven, Fairfield, Litchfield and Tolland shall serve until the annual meeting of these county associations in 1952, at which time the New Haven, Fairfield, Litchfield and Tolland county associations shall elect a past-president to serve on the State Committee on Professional Relations for a period of two years and such election shall be held bi-annually thereafter.

No member shall be elected to serve two consecutive terms of two years each, but this restriction shall not apply to the members elected originally at the semi-annual meetings of 1950. No member of the Society who is an elected officer or a member of the Council of the State Medical Society shall be eligible for election to this Committee.

The Committee shall elect its own chairman and recorder and all sessions of the Committee shall be executive sessions and not attended by others except by invitation of the Committee.

This Committee shall have no jurisdiction in legal actions relating to professional mal-practice or negligence. The purposes of the Committee shall be (1) to hear complaints and charges against members of the Society referred to it by county medical associations and (2) to hear appeals from decisions on charges reached by county medical associations or boards of censors of county medical associations.

When charges against members of the Society are received by the Society Secretary, either from the public or other physicians, they will be referred at once to the Secretary of the county association of which the physician complained against is a member and original jurisdiction in the complaint shall lie with the county association. If in the judgment of the appropriate Committee in the county association, the complaint should be heard by the State Committee on Professional Relations, it shall refer the complaint to that Committee. The member of the Committee representing the county association to which a physician against whom charges have been brought belongs shall not vote on the final conclusion reached by the Committee.

After a hearing during which the complainant and the physician against whom written charges have been brought shall be given an opportunity to appear, the Committee by ballot shall exonerate or impose such disciplinary action as it may deem appropriate and these disciplinary actions may include reprimand, suspension or termination of membership in the Society. The Committee, upon arriving at a decision, shall notify the physician against whom charges have been brought of its findings and disciplinary actions to be taken, and at the same time, file a resume of its findings and action with the secretary of the County Association to which the physician belongs and with the Council of the State Medical Society. A member disciplined by the action of the Committeee shall have the right of appeal to the Council before the expiration of fifteen days from the receipt of the Committee's findings. In the absence of such appeal, the action of the Committee is final.

COMMITTEE ON MENTAL HEALTH

Article X, Section 3, Par. 14 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Mental Health to consist of not more than eight members and nominate the chairman thereof. The Committee shall be continuously informed concerning the provisions for the care of the mentally ill in the state and those addicted to the use of habit-forming drugs and alcohol with the purpose of making information on these subjects available to the members of the Society and, if indicated, to recommend and support legislation for the improvement of the care of persons in this state so afflicted.

COMMITTEE ON THIRD PARTY PAYMENTS

Article X, Section 3, Par. 15 of the By-Laws of the Society provides:

The Nominating Committee shall nominate to the House of Delegates annually a Committee on Third Party Payments to consist of five members and nominate the chairman thereof. The function of this Committee shall be to study existing and projected systems providing payment for physicians' services by any public, private, or cooperative agency, and to advise the Society concerning them. In its operations, the Committee shall confer with representatives of such agencies and other committees of the Society having interest and responsibility in specific phases of medical care that involve payment of physicians by third party agencies.

Committees Appointed by the Council

(not requiring election by the House of Delegates)

COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

The purpose of this committee is to continue and strengthen the historic close relationship between the Connecticut State Medical Society and the Yale University School of Medicine and to further the effectiveness of undergraduate and graduate programs of medical education.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The purpose of this committee is to serve in an advisory capacity to the Woman's Auxiliary of the State Medical Society in matters of general policy, insofar as they relate to the program of the State Medical Society and upon request, to confer with the Auxiliary in the development of this program.

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

The purpose of this committee is to provide a continuing conference group between the Connecticut State Medical Society and the Connecticut Pharmaceutical Association for the study and integration of the purposes and objectives of the common problems of the professions of medicine and pharmacy in Connecticut.

COMMITTEE ON NATIONAL LEGISLATION

The purpose of this committee is to be informed constantly concerning proposed national legislation relating to medical care and welfare. The committee shall advise the Council on details of proposed legislation in the fields of health and welfare and express its opinion, with appropriate approval, to Connecticut Representatives and Senators in the Congress of the United States. The Committee shall endeavor to keep members of the State Medical Society informed on trends and developments in national legislation that may be expected to affect medical service.

COMMITTEE ON STATEWIDE BLOOD BANK

The purpose of this committee is to promote the development of a statewide blood bank operating in the interests of the people and the medical profession. The committee is authorized, in the name of the Society, to cooperate with responsible agencies such as the American Red Cross, the State Department of Health, in prescribing professional policies of the operation of a blood bank.

COMMITTEE ON MEDICAL CARE OF VETERANS

The purpose of this committee is to cooperate with the Medical Section of the U. S. Veterans Administration and to represent the medical profession in Connecticut in all negotiations concerning the medical care of veterans, the payment for such care, and matters of general medical policy.

COMMITTEE ON RURAL MEDICAL SERVICE

The purpose of this committee is to develop a program of medical service for the rural population of Connecticut in cooperation with the Council on Rural Medical Service of the A.M.A.

COMMITTEE REPRESENTING THE SOCIETY ON THE BOARD OF DIRECTORS OF CONNECTICUT HOSPITAL SERVICE

The By-Laws of Connecticut Hosiptal Service require that three of the Board of Directors of that organization shall be named by the Connecticut State Medical Society. This group is not a committee of the Society, but the three members so appointed have an important purpose to integrate the policies and ideals of the medical profession with the operation of Connecticut Hospital Service and to keep the medical profession in Connecticut informed of developments in the field of prepayment for hospital services.

ADVISORY COMMITTEE TO THE STATE BOARD OF EXAMINERS FOR NURSING

The purpose of this committee is, upon request, to cooperate and advise with the State Board of Examiners for Nursing in matters of general policy.

COMMITTEE ON THE CHRONICALLY ILL

The purpose of this committee is to be acquainted with the problems of the chronically ill in the State and to represent the Society in conferences of all agencies concerned with the care of the chronically ill.

COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

The purpose of this committee is to study maternal mortality and morbidity in Connecticut with the purpose of making their best contribution toward lowering the maternal mortality and morbidity rate from these causes.

ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

This committee was appointed, at the request of the Commissioner of Public Welfare of the State of Connecticut, to advise with him and the Medical Director of the Public Welfare Commission in all matters concerning medical care and hospitalization and to endeavor to maintain cooperation between the Commission of Welfare and the medical profession of the State.

ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT ON PSYCHIATRY CLINICS

This committee was established, at the request of the State Health Department, to advise with it on the promotion, location, and professional policies of psychiatry clinics receiving financial aid from the State Department of Health.

CONFERENCE COMMITTEE FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

This is a joint committee, consisting of representatives from the State Medical Society, the State Nurses' Association, and the State Hospital Association. Its purpose is to study problems of mutual interest to the medical, nursing and hospital administrative professions with a view to finding solutions to problems involving improvement of the care of hospital patients.

COMMITTEE ON EMERGENCY MEDICAL SERVICE

The purpose of this committee is to integrate the planning and purposes of the medical profession with the Connecticut State Defense Council and to cooperate with the Council on Emergency Medical Service of the American Medical Association.

CONFERENCE COMMITTEE WITH THE CONNECTICUT STATE DENTAL ASSOCIATION

This committee is appointed to be the conference group with the State Dental Association and to discuss with that group problems of mutual interest to the two professions and bring the professions into closer relationship in all fields.

COMMITTEE ON STUDENT MEMBERS

This committee was appointed to advise the Council on policies relating to student members of the Society and to carry out programs for the encouragement and guidance of Connecticut residents engaged in the study of medicine.

COMMITTEE ON BUILDING MANAGEMENT

The purpose of this committee is to supervise the operation of the Society's headquarters building, including all details of its financing.

BOARD OF DIRECTORS, CONNECTICUT MEDICAL SERVICE

The By-Laws of Connecticut Medical Service provide that six members of the Board of Directors of that Corporation shall be appointed by the Council of the Connecticut State Medical Society. Although this group is actually not a committee of the Society, the six members so appointed have an important purpose. That purpose is to integrate the purposes and objectives of the medical profession with the operation of Connecticut Medical Service and to keep the medical profession of Connecticut informed concerning developments in the field of prepaid medical service.

COMMITTEE TO STUDY MEDICAL EXPERT TESTIMONY

This is a temporary special committee appointed by the Council for the purpose of reviewing current standards and procedures relating to medical expert testimony and to make a report and recommendation with a view of improving this segment of medical responsibility.

Meetings Held During September

September 4—Committee on State Blood Bank
September 8—Cancer Coordinating Committee
September 17-18—Connecticut Clinical Congress
September 23—Conference Committee with Connecticut State Dental Association
September 25—Committee on Public Health
September 25—Committee on School Health

Dr. Donnelly New Clinical Director at Institute of Living

John Donnelly, M.D., has been appointed to the position of Clinical Director at the Institute of Living. In his new position Dr. Donnelly, who has been a senior psychiatrist at the Institute for the past three years, will direct the overall program for the treatment of patients and will supervise the clinical work of the medical staff.

A Diplomate of the American Board of Psychiatry and Neurology, and of the Royal Colleges of Physicians and Surgeons, in psychological medicine, Dr. Donnelly obtained his medical degree at the University of Liverpool. He interned at the Northern Hospital in Liverpool and did postgraduate work in psychiatry at the Maudsley Hospital in London, Sutton Emergency Hospital in London and Maida Vale Hospital for Nervous Diseases, London. He attended National Hospital, Queen's Square, London, and was associated with Cane Hill Hospital, Surrey, England, and with the Manor Hospital for Mental Deficiency in Epsom, Surrey.

Dr. Donnelly is a member of the American Psychiatric Association, the American Medical Association and the Royal Society of Medicine and belongs to the Connecticut State Medical Society and the Hartford County Medical Association. He is the author of papers dealing with aspects of the treatment of schizophrenia and other psychiatric subjects.

THE HISTORIAN'S NOTE BOOK

THE MEDICINE OF RUDYARD KIPLING

GEORGE BLUMER, M.D., *San Marino, California*

"The characteristic writer is a neurotic individual caught between constipation and insomnia."
Joseph Hergesheimer

IT IS hardly remarkable that so many writers of fiction have been intrigued by Medicine, for authors are not immune to sickness even though Hergesheimer's description of them is probably too general, and most of them doubtless have had opportunities of observing illness in their friends and of reading of or even noting the effects of endemic or epidemic diseases. It is clear from Kipling's own writings that he had acute tonsilitis* and that as a young newspaper reporter in India he had both malaria and dysentery. His experience as a reporter doubtless trained his powers of observation, and in his day epidemics of cholera Asiatica, typhoid fever, and plague were frequent and such pandemic diseases as influenza also occurred. In his bachelor days he constantly associated at his club with doctors who talked shop. As one reads his fascinating tales and poems, and Scribner's edition of his collected works comprises thirty-six volumes, one is impressed by the fact that he must have been interested not only in the medicine of his day, but also in the folklore of Physic. This latter fact would seem to indicate more than a casual acquaintance with medical science and art. Let us then glance briefly at some of his observations on medicine and its practitioners. We will discuss first two of his stories: "William the Conqueror" and "Love-o'-Women."

William the Conqueror, William Martyn, was not a man but an adventurous woman. In his description of her appearance Kipling writes: "In the center of her forehead was a big silvery scar about the size of a shilling—the mark of a Dehli sore, which is the same as a "Bagdad date." Kipling apparently did not know that this same disease exists in the Near East where it is known as the Biskra button, the Aleppo boil, and nowadays, wherever found, as the Oriental sore. Since Kipling wrote his description it has been found in Brazil and other South American countries and it is caused, as Homer Wright showed in 1900, by a flagellate organism very similar to that producing Dum-Dum fever or Kala-azar (Leishmania donovani). It is not transmitted by bad drinking water but by the sandfly, as was discovered long after Kipling wrote the story.

In "Love-o'-Women" Kipling describes a soldier, Larry Tighe, one of those oversexed males who, through long practice, have perfected the technique of seduction. Kipling, through Terence Mulvaney, records some of his symptoms: After an exhausting fight with the Pathans Tighe, then known as Love-o'-Women, was lying on the ground resting, and when he got up says Mulvaney: "he staggered a little, and laned over all twisted." Mulvaney suggested to him that he was wounded, but he resented the suggestion. Mulvaney, who was transferred from his regiment to Tighe's, found that the latter was trying to commit suicide by potting at the Pathans in the night in order to draw their fire. Mulvaney noticed that Tighe "Set off from the halt wid a shunt as though he was being kicked behind." Tighe admitted that he dared not kill himself but that he was in Hell and not a bullet would touch him. He told Mulvaney that drink would no longer take hold on him. One day when the campaign was over and Mulvaney was walking round the camp with him, Tighe "stopped and struck ground with his right foot three or four times." "Is that ground?" says he, and just then the regimental doctor came up. "Hold on there," said the doctor and ordered Love-o'-Women to stand at attention. "Now shut your eyes" says the doctor. "No, you must not hould by your comrade." "I'd fall dochther" says Love-o'-Women, "and you know it." The doctor ordered him to hospital and Tighe remarks that he will die slow. Mulvaney walks with him and Tighe walks with a hand on Mulvaney's shoulder "Cripplin and crum-

*The Song of the Sufferer

blin at ivry step." Later Mulvaney asks the doctor what ails Tighe. "They call it Locomotus attacks us" he saze, "bekase," says he, "ut attacks us like a locomotive," if you know what that means, "and it comes" says he, looking at me, "ut comes from being called Love-o'-Women." Later Mulvaney describes the death of Tighe in his mistress's arms, she shooting herself in the head at the same time. Here then is a story of tabes dorsalis, perhaps taboparesis, showing that Kipling was cognizant of the more striking symptoms.

Kipling's excursion into folk-medicine is revealed in a poem "Our Fathers of Old" which is a description of common herbs and their medicinal use by the people. It lists among others meadow saffron (colchicum) and valerian. We sometimes forget how many of our potent drugs originated as remedies of the people. The most publicized example is foxglove (digitalis) which William Withering put on the map after hearing of its successful use in dropsy by an old woman and confirming the observation by clinical tests.

In one of his "Puck of Pook's Hill" series Kipling describes in "A Doctor of Medicine" an interview between Puck and that interesting character Nicholas Culpeper. Culpeper is described in the Dictionary of National Biography as a physician and astrologer, a not uncommon combination in the first half of the seventeenth century. He published a translation of the Pharmacopoeia of the College of Physicians, thereby incurring their displeasure. He also wrote "The English Physician Enlarged" and "Semiotica Uranica." In his imaginary conversation with Puck regarding the plague, then raging in England, he describes seeing three rats die in the moonlight and ascribes this to a feud between Mars and the moon. Culpeper urges the peasants of the neighborhood to concentrate on killing all the rats they can find which they do, with a resultant abatement of the disease in that locality. This was centuries before the relation of rats to epidemic plague was known, though the story was written after Yersin had shown the identity of human and rat plague. It is interesting to note that the first medical book published in the American Colonies was a reprint of Culpeper's "English Physician Enlarged," Edition of 1708.

In "The House Surgeon" Kipling shows his insight into psychological problems through a ghost story. He described a haunted house once occupied by three sisters, one of whom was supposed to have committed suicide by jumping out of a bedroom window. When one of the surviving sisters is convinced that this idea is wrong and that the dear sister, an asthmatic, has accidentally fallen out of the window in trying to get air, the haunting ceases. This, of course, is hardly conventional medical psychology.

Kipling was in South Africa as a reporter during the Boer War (1899-1902) and his comments on the 8,000 cases of typhoid fever among the British troops at Bloemfontein shows knowledge of the methods of spread of typhoid which killed so many Americans during the shortly preceding Spanish-American War. As a matter of fact Almroth Wright had already devised an antityphoid vaccine and is said to have inoculated all the British forces with it. Either the vaccine was not potent enough or the regional contamination with typhoid bacilli was so overpowering that it failed. Kipling comments particularly on the carelessness in the location and construction of latrines and remarks: "the most important medical office in any battalion ought to be provost marshal of latrines." He pointed out too that not only typhoid but also dysentery was rife among the troops. All of which goes to show that Rudyard Kipling was well versed in many aspects of medicine.

Chest Physicians

A total of 932 physicians and guests attended the 18th Annual Meeting of the American College of Chest Physicians, held at the Congress Hotel, Chicago, June 5-8, 1952. The roster included members from 44 states, Hawaii, Canada and 17 other countries.

A scientific program dealing with various aspects of heart and lung disease was presented by leading physicians in the specialty. Many College members remained in Chicago to participate in the program of the Section on Diseases of the Chest of the American Medical Association.

The new president for 1952-53 is Andrew L. Banyai of Milwaukee. Francis D. T. Bowen of Hartford is a member of the Board of Governors.

Attending the meeting from Connecticut in addition to Dr. Bowen were Harold S. Bartlett, Manchester; Paul de la Vergne, Meriden; Aaron Levinsky, Bridgeport; Walter Lohrmann, Meriden; Jack Steinberg, Stamford.

THE NATIONAL HEALTH PROGRAM

Statements by the Presidential and Vice-Presidential Candidates and by Connecticut's Congressional Candidates

Each candidate from Connecticut for Congress, both Democratic and Republican, was approached for a statement on his attitude toward and opinion of the National Health Program. The JOURNAL considers it a privilege to extend to its readers these statements, together with the Health Insurance Plank of each of the two major political parties and statements by General Eisenhower, Governor Stevenson and Senators Nixon and Sparkman.

Health Insurance Plank 1952 Republican Party Platform

We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care. We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection.

Statement On Health Insurance by General Dwight D. Eisenhower, Republican Nominee for President

I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain. But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism. . . . I do believe that every American has a right to decent medical care.

In discussing Federal aid to medical education, General Eisenhower said that in private universities we must "support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization."

Statement On Health Insurance by U. S. Senator Richard M. Nixon, Republican Nominee for Vice-President

I would like . . . to express my congratulations to the members of this group, and to the medical profession generally, for the very splendid political action the medical profession took in the last campaign leading up to the November election, and in other previous campaigns. As a result of that action, I think we can safely say that . . . there is no chance whatever at this time for any type of compulsory health insurance program to be enacted. . . . On the other hand, I think you must recognize, and that all of us who are interested in this fight must recognize, that those who favor such legislation will continue to work fanatically for their cause, in the hope that somehow, sometime in the future, they will be able to accomplish their purpose.

I think . . . that a great number of people, probably a majority of the people in the country, are convinced that the compulsory health insurance programs which sound so good in theory have not worked out in action in those nations which have tried them.

I am convinced that the medical profession has taken a very long step in the right direction with its recently announced program of subsidizing medical schools on a voluntary rather than on a government

basis. I would suggest also that additional voluntary action is needed (in dealing with) the problem of encouraging wherever possible voluntary health insurance programs. It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health insurance can get it—where those who should have health insurance are encouraged to get it—but where no one in the United States is compelled to take out such insurance against his will. If the profession adopts that objective we will remove by voluntary action the strongest arguments that the proponents of government control of the medical profession have at the present time.

I believe it is essential that all members of the medical profession recognize that an attempt to socialize any American profession—any American institution—constitutes a threat to all.

Traditionally, the great accomplishments in this country have not been through government action, but through individual and cooperative action . . . (Our task) is by precept and by example, to prove to the people of the world that a free people, working as individuals, working cooperatively, can solve the problems of our society and can solve them more effectively than can a government.

Health Insurance Plank 1952 Democratic Party Platform

We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart disease and other diseases.

Research: We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

Medical Education: We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

Hospitals and Health Centers: We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health through preventive programs and health services, especially in rural areas.

Cost of Medical Care: We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

Statement On Health Insurance by Governor Adlai Stevenson of Illinois, Democratic Nominee for President

I am against the socialization of the practice of medicine as much as I would be against the socialization of my own profession, the law . . . If the insurance principle could be brought to bear on these catastrophic illnesses, it would largely eliminate the specter of terror from the average home. . . . I am sure that . . . the common objective can be largely realized without the destruction of professional independence.

Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job. I think the new commission on medical needs may well add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem.

* * * *

In a press conference on July 30, 1952, Governor Stevenson was asked "whether he saw eye to eye with Federal Security Administrator Oscar Ewing" on the issue of Compulsory Health Insurance.

Governor Stevenson's reply to this question was as follows:

No, on a number of occasions in the past I have indicated that I thought a new approach was necessary. I emphatically believe that we must find some solution to the problem of catastrophic illness and its devastating expense.

The President's Commission, of which my friend, Dr. Paul V. Magnuson is chairman, might well come up with some recommendations and suggestions which would be more palatable, and I am hopefully awaiting the result of the deliberations.

Statement On Health Insurance by U. S. Senator John J. Sparkman, Democratic Nominee for Vice-President

I am in favor of adequate medical attention for the people of this country. However, I have not favored what is generally known as Socialized Medicine.

I would be opposed to any plan which I thought would, in effect, socialize medicine, and to any medical program which would destroy the relationship of doctor and patient.

The foregoing statement was made by Senator Sparkman in an interview with Mr. Al Goldsmith, editor of *Washington Insurance Newsletter*, on July 31, 1952.

Washington Insurance Newsletter reported that Senator Sparkman strongly indicated he was opposed to the Truman National Compulsory Health Insurance Program, but declined to take a position on specific bills now before The Congress.

In 1949, when the roll was called in the U. S. Senate on President Truman's Reorganization Plan No. 1, which would have created a Department of Welfare, Senator Sparkman stood with medicine in opposition to this scheme to give Federal Security Administrator Oscar Ewing cabinet status, with increased power over the health and medical affairs of the country.

SENATORIAL NOMINEES FROM CONNECTICUT

William A. Purtell, *Republican*
Prescott S. Bush, *Republican*
William Benton, *Democrat*
A. A. Ribicoff, *Democrat*

Statement by William A. Purtell, West Hartford, Republican Nominee for the U. S. Senate

I am unalterably opposed to (a) any form of federal compulsory health insurance, (b) any plan designed to nationalize American medicine and (c) the so-called Truman-Ewing Bill.

The American system of medical care is one of the very keystones in American life. It has produced the finest system of medical care that the world knows. It would suffer irrevocable damage if it were to pass into government control.

It is not by any means perfect, nor is it as complete as might be desired. In fact, a definite need exists for greater and better health and hospital care at reasonable cost. But whatever improvements are needed can be provided by the American medical profession. Of that, I am confident. I have faith in the profession. It can achieve where government would fail.

Statement by Prescott S. Bush, Republican Nominee for the U. S. Senate

I agree fully with the health insurance plank in the Republican Party platform and I am opposed to federal compulsory health insurance.

Statement by William Benton, Southport, Democratic Nominee for the U. S. Senate

No thoughtful American would advocate—and I certainly would oppose with all my strength—any program to socialize medical care or hospitalization, or to make our doctors employees or instruments of the State or National Government.

I said in my letter to the Allied Medical Arts Committee in 1950, and repeat now, that I am opposed to and will vote against any system of government controlled medical and health services, no matter how it may be financed. Much of my adult life has been devoted to fighting socialism or collectivism in any form.

Most Americans agree also that sincere, wholehearted, and nonpartisan efforts should continue to be made so that all the people may increasingly benefit from America's great advances in medical

science. All such efforts should be carried forward in close cooperation with the medical profession and the voluntary hospitals, which have already rendered such magnificent service. In no circumstances should there be interference with the direct doctor-patient relationship, the freedom of the doctor or hospital in care and treatment of the sick, or the freedom of the patient in choosing his own doctor or hospital.

I commend the nonprofit medical and hospital plans which are applying the voluntary insurance principle to meet health needs of millions throughout the country. A further development of such voluntary plans is in the best American tradition.

However, I feel that the Democratic Party Platform for 1952 rightly recognizes the financial problem created for millions of our people by the cost of modern medical care, and rightly pledges a resolute attack on this and other health needs. I do not understand this Platform in any way as endorsing any particular health program or legislative measure in any respect.

The compulsory national health insurance bill referred to* has not even been introduced in the Senate during the past two years. It is not in the Platform; and Governor Stevenson himself has referred to this controversy as "obsolete."

The Democratic Platform does call attention to the nonpartisan Commission on the Health Needs of the Nation, which has been established to study all the facts. I have every hope this study will be carried forward, carefully and dispassionately, for the benefit of the profession, the public, and the country.

*In the letter soliciting this statement

Statement by A. A. Ribicoff, Hartford, Democratic Nominee for the U. S. Senate

As I see it the central issue is whether or not we need a tax supported program of national health insurance. My answer is that I do not think we do. And here are my reasons:

First: No program of a federal nature should be undertaken until it is absolutely and conclusively shown that the voluntary action of individuals cannot take care of a pressing and potentially dangerous national problem. Such has not been demonstrated.

Second: The nonprofit health insurance programs (Blue Cross, White Cross, etc.) are growing rapidly and seem to be well and economically administered. Through the cooperation of doctors and hospitals, these programs keep the cost of medical service within the range of all but the extremely poor. Free clinics which have been established by churches, philanthropic organizations and city governments provide ample service for the indigent. These clinics are staffed by a large number of doctors and technicians who give their time and talents without compensation.

Third: I believe and hope that the medical profession, business, labor and the community as a whole will become increasingly aware of their duty to promote an interest in maintaining philanthropic contributions to the free clinics and in selling the idea of voluntary participation in nongovernmental health insurance.

In short, I believe that we are now on the right track. As medical science increases its skill and as medical care becomes better and more costly we must redouble our promotional efforts. State and private universities must get more money for medical education; voluntary contributions to hospital drives must increase in size and number; basic medical research must continue; and all possible voluntary cost-cutting devices should be given the widest publicity.

If the responsible medical associations get together with the responsible men and women of business, labor and education, they can solve the problem of national health by voluntary action without government intervention.

NOMINEES FOR HOUSE OF REPRESENTATIVES FROM CONNECTICUT

1st District
THOMAS DODD, *Democrat*
JOHN ASHMEAD, *Republican*

2nd District
WILLIAM M. CITRON, *Democrat*
HORACE SEELY-BROWN, JR., *Republican*

3rd District
JOHN A. MCGUIRE, *Democrat*
ALBERT A. CRETELLA, *Republican*

4th District
JOSEPH P. LYFORD, *Democrat*
ALBERT P. MORANO, *Republican*

5th District
JOHN A. SPEZIALE, *Democrat*
JAMES T. PATTERSON, *Republican*

Democratic Representative at Large:
ANTONI N. SADLAK, Rockville

Republican Representative at Large:
STANLEY J. PRIBYSON, Hartford

Statement from Thomas J. Dodd, Democratic Nominee for Congress, 1st District

I am unalterably opposed to any compulsory tax supported National Health Service.

I am in favor of a sound health program which assures the maximum medical coverage to the greatest number of American people.

I prefer to see this done through private facilities.

However, as the father of six growing children and having paid their doctors' bills and hospital bills for more than 17 years, I have some knowledge about medical costs.

Even for a family that has been fortunately free from prolonged, serious illness, the burden of medical care is a heavy one.

I believe that the voluntary nonprofit health insurance plans that are already in operation have been most helpful to a great number of people, and I am hopeful that the insurance industry together with nonprofit health insurance enterprises will be extended so that a vastly larger number of people can be covered.

I am hopeful that we can have cooperative effort between the members of the medical profession and public officials, and particularly, I would like to see this problem removed from the area of partisan politics.

Statement by John Ashmead, Windsor, Republican Nominee, 1st Congressional District

I find myself in sympathy with the Health program as outlined in the 1952 Republican Platform.

May I add that I have a decidedly American distaste for any legislation that tends to curb initiative and the liberties guaranteed us under the Constitution.

Sorry for the delay in this answer but a candidate, particularly in Hartford County—and a Republican—must keep on the aggressive if he is to overcome a sentiment created by the party in power, which in spite of proofreading, sometimes is named the "giverment."

Offering -- nationally famous makes of

FURNITURE, EQUIPMENT and SUPPLIES including:-

W. D. Allison Company

Shampaine Company

Ritter Company

Welch-Allyn Company

Johnson & Johnson

Armour Laboratories

Raytheon Manufacturing Co.

Birtcher Corporation

J. Sklar Manufacturing Co.

Davol Rubber Company

Seamless Rubber Company

Becton, Dickinson & Company

Americaine, Inc.

North American Philips Co.

and many others



One section of our large display room in Bridgeport

Telephone 5-3116 -- Enterprise 3190

American Surgical

SUPPLY and EQUIPMENT CO.

1715 BARNUM AVENUE P. O. BOX 150

BRIDGEPORT, CONNECTICUT

Statement by William M. Citron, Middletown, Democratic Nominee from 2nd District

To me the practice of medicine, surgery, dentistry and allied practices are professions like my own profession of law, and as such are individualistic activities, where learning and experience are the foundations for one's career. I am opposed to any further governmental restraints upon these professions, except what we have upon the statute books now.

I believe that old age pensions should conform more equitably with cost of living standards, and so I advocate that at the present time the amounts might be increased. But I do not believe that statutes are needed directing the beneficiaries how to use the proceeds, whether they pay old bills, present bills, or what to do with this insurance money. As human beings, even though of the aged category, they have a sense of responsibility.

I am opposed to the establishment of a compulsory tax supported national health service. In my opinion the platform of the Democratic Party adopted at Chicago does not advocate compulsory taxes for this. We should endeavor to have voluntary nonprofit health insurance extended to the masses of our population, particularly to those of the lower economic status. My observation is that the present idea of the voluntary nonprofit method (like Blue Cross, for example) stimulates a sense of individual responsibility and pride, and we should therefore encourage its extension to include more and more people.

Statement by Horace Seely-Brown, Jr., Pomfret Center, Republican Nominee from 2nd District

I believe that the fundamental issue confronting the people of our country in this election is, shall we vote to make big government bigger, and thereby send our nation still further down the path towards totalitarianism, and away from the democracy which we preach, but which, in some important particulars, we turn away from practicing.

I believe that we have got to put a stop to further entrenchment of the all powerful federal bureaucracy. Even that is not enough. We must start now on unbuilding it, not merely because it costs too much, although that is reason enough, but because by its very nature it is tending to destroy the federal republic as it was founded by our forefathers and fostered and strengthened by those generations which preceded us.

I believe that the federal government ought not to do things, ought not to attempt to perform services, that can be done better by individuals, by groups of states, or by the states.

As a Republican nominee for Congressman from the Second District, I stand, with the other members of the Republican team, on the principles of the 1952 Republican platform, and believe that in this important year of decision, the interests of all of the people will be best served by electing to office a Republican President and a Republican Congress.

Statement by John A. McGuire, Wallingford, Democratic Nominee from 3rd District

In reference to the sentence of the 1952 Democratic Platform advocating a "resolute attack on the heavy financial hazard of serious illness," it is my belief that this sentence is intended to refer to the various solutions to the Nation's health problems now being studied by the bipartisan Commission on the Health Needs of the Nation.

I was very pleased to note the statement of your secretary, Dr. Barker, that voluntary health insurance "now covers more than a half million people in Connecticut and probably twenty-five million in the country." I hope this coverage will continue to grow so that every family will be assured of adequate family care, thus eliminating the seeds of the bitter controversy we have seen develop over National Health Insurance.

I am certain that your members are aware of the fact that I am a member of the House Interstate and Foreign Commerce Committee before which all National Health legislation comes.

Statement by Albert W. Cretella, North Haven, Republican Nominee from 3rd District

I subscribe heartily to the Health Plank of the Republican Party's platform. The experience of Great Britain with socialized medicine, with its inefficient service to patients, waste of the taxpayers' money and bureaucratic interference with the physician, is an object lesson we cannot safely ignore. Government, the physician, the voluntary hospital and the voluntary health insurance programs must work as partners, but federal domination of health services must be shunned like the plague. The Republican Party's stand on a national health program offers a steady improvement in medical care and health protection, with continued independence of the medical profession and patients.

Statement by Joseph P. Lyford, Democratic Nominee from 4th District

The physical and mental health of our people is a matter of equal and earnest concern to every American, regardless of whether he is a factory worker, a teacher or a doctor. On this we can all agree.

We have serious problems to overcome in raising the health level of our population. Through research we must discover new and better ways of combating illnesses like heart disease, cancer, arthritis, mental disorders, etc. Through education we must provide the average citizen with better knowledge of how to avoid costly minor illness. We must increase the number of doctors, dentists, laboratory technicians and nurses. We must discover ways in which to bring adequate medical care to more of our people. Finally, we must devise ways of lessening the heavy financial blows of catastrophic illness on families of low and moderate incomes. Most citizens can agree on these points also.

None of these problems can be solved unless the medical profession itself, notably the doctors, provides leadership and the desire for progress. In the past progress has been made and leadership has been available. But we need more than medical leadership. In the future the cooperation of the entire citizen community must be enlisted in the doctors' work if we are to solve the financial, research and treatment aspects of disease.

I believe that the government of the United States, as well as state government, has a responsibility to assist the medical profession in overcoming the obstacles to better health for all. The federal government can and should provide help in the gigantic research problems ahead; exploration for the answer to cancer is as important to humanity as the development of atomic energy, and our government should assist in both enterprises. Of all our natural resources health is most important, and government has a part to play in this conservation program.

Our shortage of doctors, dentists, trained nurses, hospital administrators, etc., is another serious problem in which the federal government must be prepared to stand by its people and the leaders of the medical profession. These and the other problems enumerated require the help of government if they are to be solved.

The problem of how government should cooperate is an unsettled one. The President has appointed a fair minded committee headed by distinguished leaders of the medical profession to ascertain the means whereby doctors, government, and the public, working together, can achieve the objective of a constantly rising health level. In proposing any specific steps in such a program, I would be strongly influenced by what the commission will recommend.

Meanwhile, however, I believe it is important that we encourage the growth of voluntary, nonprofit hospital insurance, the coverage of which at present is only sketchy. Likewise, the research performed by such groups as the American Heart Association, the United Cerebral Palsy Association, the Cancer Foundation, and others, be stepped up as much as is financially possible.

I believe that it is highly important that at no point do we allow government to interfere in any way with the medical practitioner's professional methods of doing things. The relationship of a bona fide doctor to his patient must be protected from all outside meddling, political or otherwise. Government's part in advancing the nation's health should be in the form of assistance, rather than compulsion.

Until we cooperatively work out a plan for dealing with disease on a broad and effective basis, there are mistakes which must be avoided. For instance, doctors must exert the greatest care in holding the position of high respect in which they are held by the community at large. This means that the medical profession cannot allow itself to be represented

by spokesmen who do not have the best interests of the public at heart. Such spokesmen can and unfortunately have, at times, created suspicion and distrust of the medical profession on the part of the public.

In its turn the public must recognize that the overwhelming majority of members of the medical profession are sincerely desirous of improving the physical and mental well being of their fellowmen. Most of them are doctors and dentists and nurses because they are impelled by a desire to alleviate suffering and combat disease.

Finally, I would caution government to seek the advice of reputable and disinterested members of the medical profession at every point in the search for a formula to a successful national health program. Compulsion or selfish political pressures cannot be tolerated.

If such a procedure is followed, I am sure that America will finally obtain the doctors, the hospitals and the research facilities it needs for the future, and it will thereby follow through successfully on the objective set by the Democratic Platform of 1952.

Statement by Albert P. Morano, Greenwich, Republican Nominee from 4th District

I am flatly opposed to any program smacking of Socialized Medicine. I opposed any such measures in my 1950 election platform. I voted against the Social Security Bill of the 82nd Congress the first time it came to the floor of the House because it contained a clause which opened the door to this Administration's proposed plan for a National Health Insurance Program. I still remain flatly opposed to any programs that have the slightest tendency toward socializing the medical profession.

The health of this nation's citizenry is extremely important to the future welfare of the country. Proper medical attention for people in all walks of life is of the utmost importance. The existing problems of wider and better medical attention cannot, however, be accomplished with any degree of satisfaction by a program of nationalizing medical care. The experience of Great Britain in this field presents a poignant picture clearly showing that the failures outweigh the gains in a Socialized Health Program.

Statement by John A. Speziale, Torrington, Democratic Nominee from 5th District

I fully appreciate and understand what the term socialized medicine connotes and I am as much opposed to the socialization of medicine as I am to the socialization of law, my own profession.

Admittedly, the problem of adequate medical treatment for all our citizens is a very important one; however, as a professional man, I sincerely feel that any suggestions or changes concerning the problems that confront a particular profession should originate from the profession itself.

My interpretation of the term "resolute attack" of the platform adopted by the Democratic Convention is that it does not mean the establishment of a compulsory tax supported system of medical care to which I am most strongly opposed.

The creation of an expert nonpartisan commission to determine the health needs of the nation will prove beneficial. However, this commission should work in conjunction with the medical profession.

I am strongly in favor of the promotion and expansion of a voluntary nonprofit health insurance plan such as we now have in Connecticut, and of which I am a member. After this nonpartisan commission and the medical profession have completed their findings and have determined our medical needs, I believe that the solution of this problem will be in the promotion and expansion of such a voluntary plan.

Partisan politics has no place and should not interfere in a matter which is so vitally important.

Statement by James T. Patterson, Waterbury, Republican Nominee from 5th District

I say to you that compulsory health insurance would put medical care on an assembly line which may be fine for mechanical production but not for the health of our nation.

Socialized medicine is political medicine and it would be certain to develop into political quackery. A compulsory national health program is a step in the direction of socialized medicine and is not the American way—it is not for the people of our country. I am convinced that the American people don't want it. I am further convinced that the American people will give their answer at the polls on November 4 and their answer will be a resounding endorsement of American medicine and the American way of life.

Statement by Stanley J. Pribyson, Hartford, Democratic Nominee for Representative at Large

It is my pressing desire, during this campaign, to speak frankly and plainly on all the important issues of this campaign, so that the voters can decide intelligently which candidate they desire to represent them in Washington.

At this time, I want to inform you in response to your queries that, frankly, I have no glib, absolute answers. On purely tactical, political grounds, I suppose, it would be advantageous for me to give you simple, pat answers; but it would not be intellectually honest for me to do so.

The problems your questions pose are extremely complex, defying simple solution. I happen to be a candidate for political office. Naturally, anything I say or do, at this time will be construed as a means to win votes. You, on the other hand, are not a candidate for political office. Nothing, therefore, you say or do can possibly be attributed to political motivation. Yet, I think we can be on common ground and in full accord when I say that I believe in greater and less expensive medical services and in better and more accessible hospitalization so that the measure of the medical treatment an individual receives will be regulated wholly on his need for that treatment, and not on his ability to pay for it. Nobody with humanitarian sentiments can quarrel with these beliefs and objectives.

Argument and disagreement arise, however, not over these beliefs and objectives, but rather how they can be realized. I myself have no specific suggestions as to how these objectives can be attained. It involves a great deal of study, research and reflection. Indeed, it is easy to propose attractive, theoretical plans; it is infinitely harder to put those plans into practice so that they become more than just a temporary palliative which, in the long run, aggravates the problems instead of solving them. Such was the unfortunate experience in Great Britain.

Because of the complicated nature of the problems facing the medical profession and the ineffectuality of most government plans up to now proposed, it is my hope and expectation that the medical profession will be able to solve the problems of medical care to meet the needs of all the American people without governmental intervention. The progress already made by the medical profession, the medical societies, and medical schools provides a strong base for my belief that the problems can be solved, and the objectives attained by the profession itself. I know a little of the magnitude of the task. Indeed, we must have patience and give the profession time to develop and work out its problems. I am confident that it can and will do it and meet the challenge which confronts it. However, if it show no, or little, inclination to do so then there are alternatives that must be examined, a decision reached, and a feasible plan adopted.

I am certain that you will agree with me that the practicing physician, like the clergyman, holds a position in our society which, by its very nature, behooves him to be of service to mankind in a broad, philanthropic manner. This, of course, means that the physician must keep his office door open to all, and attend to the genuine medical needs of every individual who calls upon him, regardless of that individual's ability to pay for professional services. If the medical profession adheres to such a humanitarian policy, then there will be no need for a government sponsored program, for the medical profession, acting voluntarily, will have demonstrated that it can and is willing to solve those problems and achieve those goals that would be the function and object of a government program.

Statement by Antoni N. Sadlak, Rockville, Republican Nominee for Representative at Large

In view of my previous verbal and written statements and my voting record in the House of Representatives, it seems almost superfluous that I should again try to express my feelings about so-called socialized medicine.

In no way have I found reason to change from my established opposition to such a program and I do endorse the Health Insurance Plank presented by the Republican Party Platform because it unequivocally states my feelings in the matter.

WISHES AND VOTES

Every American wishes to preserve democracy and good government — but a vote must be tied to every wish to make it come true.

Heavy voting is the key to good government. Be sure your vote helps turn the key on election day.

REGISTER AND VOTE

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette J. Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon
John O'L. Nolan, Hartford

First PR Institute

The first Public Relations Institute to be sponsored by the American Medical Association was held September 4-5 at the Edgewater Beach Hotel, Chicago.

The highly successful conference was attended by 175 executive secretaries, public relations directors and business managers from state and county medical associations in 40 states.

The program featured presentations by 33 speakers and general topics for the morning and afternoon sessions were The County Society's Place in Community Affairs—Medicine and Publicity—Practical Ways to Increase Physician Participation in Society Activities—Strengthening Medical Society Public Service Activities.

Dr. George F. Lull, AMA secretary and general manager, declared in his message of welcome that public relations programs have brought increasing numbers of physicians into active participation in the affairs of their medical associations.

In a panel discussion on development of relationships with press and radio, Edward Lindsay, editor of the Decatur (Illinois) Newspapers, Inc., emphasized that "your competition is misinformation or lack of information, not ignorance."

"You do not need to fear the public," he declared. "It is fair, just and decent—if it has a chance to be."

Speaking on the topic "What is Community Relations?," Fred R. Jolly, manager of the Community Relations Department of the Caterpillar Tractor Company, Peoria, Illinois, outlined the industrial approach to winning community support and stressed that today this is a common objective of both medicine and industry.

"Our emphasis is in doing our work at home," he said, and added that "we no longer view our plant as a jumble of bricks and mortar, but as a good citizen of our community."

Workshop sessions on a number of activities were held throughout the conference to discuss problems and their solutions. Topics included how to work with farm groups, schools and Parent-Teacher Associations, women's clubs, service clubs and veteran groups; getting the best results for emergency call services mediation committee activities and speakers' bureaus; and understanding the viewpoints of newspaper, radio and television personnel.

Several motion pictures concerning the progress of medicine were shown during the conference and the concluding session featured clinics on field service, radio and television programming and newsletter editing.

New Radio Program for New Haven County

A new 13 week radio series titled "Your Child Goes to School," is being broadcast by station WNHC, New Haven, as a public service.

The series is being sponsored by the New Haven County Medical Association under auspices of the Woman's Auxiliary to the State Medical Society.

The first program in the series was aired Sunday, September 7. Other programs are scheduled for each Sunday, 4:30 to 4:45 P. M., through December 7.

The series was produced by the Bureau of Health Education, American Medical Association, and is one of many similar radio recordings available for use without charge by local medical associations.

New Emergency Plan in Milford

The Milford Medical Society recently inaugurated a 24 hour emergency medical call system to serve residents in that community and adjacent areas.

The new service, announced in the August 14 issue of the *Milford Citizen*, operates through the

switchboard of the Milford Hospital, but is independent of the regular hospital emergency services. A list of physicians available for emergency care is on file with the switchboard operator.

The Milford service is similar to plans sponsored by medical associations in a dozen principal Connecticut communities. These have been expanded in the past 18 months to serve more than one million Connecticut residents, half the state population. They are located in Hartford, New Britain, Manchester, Waterbury, Torrington, Danbury, Bridgeport, Norwalk, Stamford, Greenwich, Putnam and Norwich.

Connecticut Program Outlined in AMA Publication

PR Doctor, the public relations newsletter of the American Medical Association, devotes a full page of its September issue to the community service activities of Connecticut's medical associations.

The article mentions *Main Street Frontier*, the seven-point community service program of the Society's Public Relations Committee, and *Your Community, Your Future*, the brochure of the Public Relations Committee of the Woman's Auxiliary. It also outlines the development of emergency medical call plans throughout the state.

PR Doctor is published six times a year to keep state and county medical associations informed concerning the progress of medical public relations programs and activities.

VA COURSE IN PSYCHIATRY AND NEUROLOGY FOR GP's

The Veterans Administration is instituting a four-month intensive training course in psychiatry and neurology to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the VA Hospitals in Coatesville, Pennsylvania; Palo Alto, California; and a joint Downey-Hines, Illinois, program near Chicago, Illinois. Physicians will be employed at salaries commensurate with their training and experience (salary range: $5,500 to $11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

Information and applications may be obtained from your nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

An Appeal — Urgent

Mrs. Peter F. Smith, formerly of Greenwich, Connecticut, now of Wyoming, reports the disappearance of her daughter Constance, aged ten. This young girl 5 feet tall, 85 pounds in weight with brown hair and blue eyes and a small scar under the right nostril attended a Camp Sloan near Lakeville, Connecticut, this summer. On the morning of July 16 she walked from the camp to the village and disappeared. No trace of her has been found since then.

Constance Smith had a strabismus operation in 1950 to correct an exotropia. She is extremely nearsighted wearing the following glasses:

O.D. −4.00 −1.00 cyl axis 180
O.S. −4.25 −1.50 cyl axis 180

Write the CONNECTICUT STATE MEDICAL JOURNAL if you have any information about this girl.

Group Health and Accident Insurance Extended

Arrangements have been made with the Commercial Insurance Company of Newark, New Jersey to extend the illness coverage under our group accident and sickness policy.

The maximum period of 52 weeks, now in effect, can be increased to 104 weeks for a small increase in premium.

It is necessary for 50 per cent of the insured members under age 65 and who are working on the specified date to make make application for the plan to become effective.

Those who enroll in this two year sickness plan may continue this coverage to age 70. At that time, the member's coverage will return to the basic group plan now in effect, with a corresponding reduction in premium.

This two year sickness plan is optional with each insured member.

Those members who are eligible will receive in the near future a letter from the office of Arthur W. Eade, advising each member the cost and the steps needed to institute this program.

NEWS FROM WASHINGTON

Health Legislation in 82nd Congress

In 1952, Congress considered but withheld approval of bills strengthening Federal support of local public health units; giving financial aid to medical, dental and nursing education; establishing a Department of Health. It authorized equal rights for women in medical branches of armed forces (Public Law 408); extension of $100-a-month special pay for military physicians and dentists (P.L.410); extension of water pollution control law to June 30, 1956 (P.L.579)—and that is just about the story.

Out in periphery, with medical implications of one kind or another, were social security liberalization (HR7800); amendment of Defense Housing Act (S3066); reorganization of reserve components of military services (HR5426); Federal aid to Hawaii for care of leprosy cases (HR1739); GI educational and training benefits for Korean veterans (HR7656). These were passed and signed by the President.

With exception of appropriations measures and sundry items of extremely limited application, no other bills having any direct bearing on health sciences achieved enactment in 1952. Legislative record was even thinner than that of 1951 session of 82nd Congress, which likewise passed few important measures. Among them were Durham-Humphrey amendment of Food and Drug Act, tightening control of prescription drugs; Defense Housing and Community Facilities Act (aid for hospital expansion in critical defense areas); amendment of Selective Service Act to provide deferment equality for pharmacists, chiropodists and chiropractors.

Companion bills calling for special study of deaths and illness among American war prisoners and internees actually passed House and Senate but latter subsequently reconsidered vote and project was not enacted.

Public hearings were conducted in 1952 on a plan to revive Emergency Maternity and Infant Care program of World War II, on reorganization of Veterans Administration and on income tax relief for doctors, lawyers and other self-employed persons wishing to set up retirement annuities but adjournment placed all of them on the shelf. It is wholly probable that new legislation along same lines will be introduced after 83rd Congress convenes in January.

While reluctant to take decisive action on national health legislation, the 82nd Congress was a prolific incubator of investigations, several of which cut across the medical field. A 2 year House inquiry into chemical additives, concluded last spring, produced reports on fluoridation of drinking water as well as on health safeguards in manufacture of cosmetics and processing of foods. Senate Labor and Public Welfare Committee investigated Veterans Administration, with special attention to its large medical department, and sponsored a comprehensive study of health insurance plans.

Earlier this year, House ordered special inquiry into philanthropic foundations, work on which is just getting under way. Authorization probably will be requested for continuation of this investigation into 1953.

Demise of the 82nd Congress will automatically inter scores of bills that were enthusiastically introduced in House and Senate but made no further headway than shelves of legislative committees. Most were Fair Deal measures that would have appropriated millions in Treasury funds for assisting professional education, local public health units, outpatient clinics, medical care cooperatives, voluntary prepayment plans, group medical practice enterprises, and diagnostic centers. And, of course, one of dormant bills provides for system of compulsory health insurance.

Surprisingly enough, however, Senator James E. Murray (D—Montana) made no effort in 1952 in direction of c.n.h.i., a mission with which he has been closely identified for years. But he and Representative John Dingell (D—Michigan) did introduce a bill giving government-paid hospital care to persons 65 and older but it died in committee. Note: Sole Republican member actively associated with financial aid to professional education was Representative Frances Bolton (R—Ohio), who tried hard but in vain for nursing school subsidies.

It goes without saying that many, and probably most, of the bills that failed of enactment in 82nd

Congress will be reintroduced next year. And along with them, some new ones, with new slants.

Council Approves Plan for Medical Department Scholarships

Meeting in Pentagon September 8, Armed Forces Medical Policy Council gave final approval to detailed plan for establishment of scholarships in schools of medicine, dentistry, nursing and veterinary medicine. A bill has been drafted for consideration by Congress when it reconvenes in January. Objective of program is to provide a steady annual increment for three services' Medical, Dental and Nurse Corps and the Veterinary Corps of Army and Air Force. This would be accomplished under a provision that scholarship holders shall be obligated to serve in uniform—following completion of professional training—for as many months as he (or she) went to school at government expense. However, an escape clause permits scholars to withdraw from program at any time, on condition that they pay back the stipends and subsidy money expended in their behalf by U. S.

Proposed legislation, in present draft form, sets no ceiling on number of scholarships to be created. Pentagon's plan is for 300 medical, 126 dental, 13 veterinary and 359 graduates annually, to be distributed among Army, Navy and Air Force. Prospective scholars would be nominated by deans, with the armed services making their selections from these candidate lists. For subsistence, all four classes of students would receive stipends of $133 a month, except that student nurses would get $50 if room and board were included in tuition fee. To cover tuition, laboratory expenses and other necessary costs, medical colleges would receive $2,800 per student annually; veterinary schools, $2,050, and nursing schools, a maximum of $1,800. Reimbursement figure for dental schools has not yet been set.

Whether participants would receive the extra pay of $100 a month, while in obligated military service following graduation, which goes to medical and dental officers is still undecided. Note: Medical, dental, veterinary and nursing educators collaborated with military officials during many months of study that preceded Council's approval recently. Formal approval by AMA, ADA and other interested professional societies will be sought by Department of Defense to help toward Congressional enactment.

Rusk Advisory Group Reports on Health Resources Progress

Accomplishments of its second year of operation are summarized in annual report of Health Resources Advisory Committee, issued recently. Covering period ended August 31, report cites role taken in organizing unified national blood program, surveying health personnel requirements of civilian population, coordinating military medical manpower needs, and cooperating with Federal Civil Defense Administration. Attention also is given to its activities as an advisory body to Selective Service in connection with administration of doctor-draft law. Sole recommendation is that Health Resources Advisory Committee, or a counterpart thereof, should be a permanent arm of Federal government, rather than a temporary emergency agency (attached to Office of Defense Mobilization) as presently constituted, under chairmanship of Dr. Howard A. Rusk, of New York.

"It is vital that somewhere in the Federal government, and at a sufficiently high organizational level to make its work effective, there must be a coordinating body in the health field if full utilization for both civilian and military needs is to be made of the health potentials of our nation," the Rusk report concludes.

Brookings Publishes Health Resources Volume, Cites U. S. Health Gains

Medical and health gains in the past 50 years are cited in the 352 page volume titled *Health Resources of the United States* which Brookings Institution published in August. The book is described by the institution as "the factual foundation for future Brookings publications in the field which will offer analyses of a number of scientific and social problems relating to health." The volume is the work of George W. Bachman and associates, who spent three years in research. The institution said more than 700 private and public agencies contributed material for analysis.

The book is divided into three parts. Part I reviews the state of the nation's health during the first half of this century. Part II deals with health personnel, including medicine, dentistry, nursing and auxiliary personnel, and also medical group practice. Part III is devoted to hospitals and related facilities, specified diseases and disabilities, environ-

mental health, federal health services and health service in industry. Copies are available at Brookings Institution, 722 Jackson Place N.W., Washington 6, D. C., at $5 a copy.

Army Announces Programs to Ease Shortage of Nurses

Army Medical Service is planning two steps in an attempt to ease the shortage of nurses. It will broaden its practical nurse training program this fall with two new 48 week courses in advanced medical-technical procedure, opening October 27 in Dallas and San Francisco. Army also plans a 3 month intensified campaign starting next February for recruitment in the Army Nurse Corps and Women's Specialist Corps. If the call for 500 nurses and 125 medical specialists can't be met by volunteers, Army will begin calling women from its organized and voluntary reserves. Meanwhile, Air Corps says it is getting enough nurses through volunteers and Navy reports an adequate supply of nurses through voluntary recruitment of reserves.

Medicine Is Largest User of Isotopes; AEC Coordinating Committee Named

Atomic Energy Commission reports over 35,000 shipments of isotopes have been made during past six years, with about 13,000 shipments in the medical field. AEC also announces appointment of an Ad Hoc Committee made up of officials of AEC, Food and Drug Administration and National Institutes of Health. It will handle problems arising from increased distribution and use of isotopes that overlap jurisdiction of the three agencies.

PHS Closes Four Hospitals As Result of VA Budget Cuts

A reduction of $1.5 million in Veterans Administration contract to U. S. Public Health Service for care of VA general medical and surgical patients has resulted in closing of four PHS hospitals. VA cut its contract from 1,005 beds last fiscal year to 375 beds this year.

Setting September 15 as a target closing date, PHS plans to alter the hospitals for use as outpatient clinics, employing some of the 350 affected personnel in these clinics and transferring most others to other government facilities.

The hospitals, with a total bed capacity of 448, are located at Kirkwood, Missouri; Mobile, Alabama; Portland, Maine, and San Juan, Puerto Rico. Last year 53 per cent of all patients in these hospitals were VA contract cases. Because of its budget cuts, VA has now reduced its contracts for PHS, Army and Navy hospital space by $2 million but will continue to place VA patients in public and private tuberculosis and neuropsychiatric hospitals.

Health Commission Panel Proposes Turning Federal Hospitals Over to Communities

A panel group of the President's Commission on the Health Needs of the Nation proposes that hospitalization for federal beneficiaries be provided locally. The panel on medical care of veterans and other federal beneficiaries suggests that existing federal hospitals be turned over to communities "for nominal fees" with the federal government paying the costs of hospitalizing its cases. The panel would place responsibility for staffing and operating hospitals with the communities. Such a procedure, the panel stated, "would eliminate competition between federal and local hospitals for scarce medical personnel, would make medical care equally available to all federal beneficiaries and would eliminate the problem of administering a large and bulky service." The commission has taken no action on the proposal, which was presented during a two-day open session. The commission makes its final recommendations to the President in December.

The proposal was opposed by Vice-Admiral Joel T. Boone, chief medical director of Veterans Administration. He said it would result in a "super colossal" hospital operation and "spotty treatment" for veterans.

Dr. James C. Sargent, chairman of the AMA Council on National Emergency Medical Service, appearing on one of the panels, stated the AMA was opposed to unwarranted extension of medical care to dependents of service personnel. Dr. Sargent also noted the AMA was concerned over proper utilization of physicians in the armed services. The commission was informed by Dr. Anthony J. J. Rourke, president, American Hospital Association, that because of increased volume of private patients under prepayment health plans, there has been a marked drop in the number of ward patients for the teaching services. He said if this trend continues, ". . . some other way will have to be found for training the doctors of tomorrow."

American Legion Action On Medical Matters Summarized

American Legion offices in Washington have made public a digest of resolutions approved by its Committee on Rehabilitation and subsequently adopted on floor of national convention in New York on August 28. Legion is on record: Opposing budgets imposed on medical and other services of Veterans Administration; favoring establishment of liaison committees with medical and dental societies and hospital associations in all State Departments of the Legion; favoring transfer to VA of hospitals declared surplus by armed forces; urging Congress to provide for necessary treatment of medically indigent veterans, regardless of service connection; opposing "any sort of covenant which would bring about by international treaty or otherwise any type of socialized medicine."

Resolutions supporting chiropractic services for veterans, submitted by Legion Departments of Arkansas, Mississippi, Minnesota, Illinois, Nevada, New York and Texas, were all rejected. Also disapproved were Mississippi and Michigan resolutions designed to further the cause of visual examinations by optometrists. Likewise a bold resolution from Washington State whose purpose was to curtail VA hospitalization for non service connected disabilities.

Doctors May Deduct Split-Fee Sums, Revenue Unit Rules

Ethics to one side, fee splitting is quite legitimate as far as Bureau of Internal Revenue is concerned. It has ruled that split-fee sums which a surgeon, for example, remits to a physician for case referrals represent deductible business expenses, for income tax purposes. Same ruling states that practitioners also may deduct, as ordinary business expenses, amounts paid out for professional assistance of any necessary nature. In its split-fee decision, BIR was influenced by outcome of Supreme Court case last spring in which "kickback" money, passed from two North Carolina optical firms to physicians prescribing eyeglasses, was held to be necessary and legitimate. In current ruling (published in September 1 issue of Internal Revenue Bulletin), BIR explains:

". . . as a general rule, such (fee splitting) payments are deductible for Federal income tax purposes provided they are normal, usual and customary in the profession and in the community; are appropriate and helpful in obtaining business; and do not frustrate sharply defined National or State policies evidenced by a governmental declaration proscribing particular types of conduct."

Civil Defense Allocates $15 Million to States For Medical and Other Supplies

Federal Civil Defense Administration has completed the allocation of $15 million to the states, which must match the funds with state or local money or forfeit the federal contribution. Money will be spent for medical supplies and equipment, attack warning and other communications, fire-fighting and rescue equipment and for training and public education. Because medical supplies up to now have accounted for about 90 per cent of all CDA expenditures, it is expected that a large percentage of the new allocation also will be used for this purpose.

Connecticut will receive $196,000.

Still pending is a decision by FCDA on the breakdown of $20 million voted by Congress for federal stockpiling of medical supplies. The issue is how much to spend on the blood program.

VA Reduces Average Patient Load in Hospitals Because of Budget Cut

Because of a 5 per cent cut by Congress in Veterans Administration's medical care budget, the agency has decided to reduce the average patient load in its own hospitals by 2,800 (from 102,000 to 99,200). Also, it is giving up some beds it had contracted for in other federal hospitals. Despite the restriction, no patients will be discharged before completion of treatment, but it is anticipated fewer non service cases will be admitted. Most recent VA statistics (August 1) show a total of 19,376,000 veterans in civilian life, including just over a million with service since start of the Korean War.

Chloromycetin With Due Caution Approved by FDA

Food and Drug Administration verdict, announced August 18, permits continued distribution and use of chloramphenicol (Chloromycetin) provided its label and circulars carry prescribed warnings on patient surveillance and contra-indications



THE COUNCIL-ACCEPTED USES OF

Dramamine®

NOW ARE:

SYMPTOMATIC CONTROL OF NAUSEA AND VOMITING ASSOCIATED WITH	*pregnancy* *therapy with certain drugs* (*antibiotics, etc.*) *electroshock therapy* *narcotization*
MANAGEMENT OF VERTIGO IN	*Ménière's syndrome* *radiation sickness* *hypertension* *fenestration procedures* *labyrinthitis*
MANAGEMENT OF VESTIBULAR DYSFUNCTION ASSOCIATED WITH	*Streptomycin therapy*

Tablets: 50 mg. each
Liquid: 12.5 mg. in each 4 cc.

—and, of course, MOTION SICKNESS

Dramamine®

BRAND OF DIMENHYDRINATE

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

for use. Outcome of the case, in which special committee headed by Dr. John H. Dingle and appointed by National Research Council served FDA in technical advisory capacity, reveals that Army medical department was nearly three months ahead of the pack in recognizing drug's potential hazards and acting accordingly. FDA decision specifies that circulars are to state that blood dyscrasias may be associated with its administration, caution against indiscriminate use and advise making adequate blood studies when this potent antibiotic is given. These warnings are substantially same as Army directive to all hospitals and medical activities last May.

Dingle committee studied records of 410 cases of serious blood disorders, many of which ended fatally, in 177 of which Chloromycetin was found definitely to be a factor. In 61 cases, this was only drug administered and in remaining 116 there were other drugs to be reckoned with. Deaths in each group approximated 50 per cent. In 168 cases it was determined that Chloromycetin had not been given, and 65 others are still under study.

"Credit to Researchers"

Parke, Davis & Co., producers of Chloromycetin, said FDA's decision "certainly reflects new credit on the research scientists who discovered and perfected Chloromycetin, and the clinical investigators who made exhaustive tests before Chloromycetin was first made available to the medical profession." Its statement noted that 8,000,000 patients have been treated with the drug since 1949. Meantime, Dr. Dingle's study group recommended that further study of serious reactions to this and other drugs be encouraged, adding that military and veterans hospitals can be of great value in this regard.

Hoxsey Ruling Strengthens Federal Prosecution Authority, FDA Says

A U. S. Court of Appeals decision in the Hoxsey Clinic of Texas case has greatly strengthened the hand of the government in its fight against worthless cancer remedies, according to Food & Drug Commissioner Charles W. Crawford. The decision was handed down at New Orleans, reversing a District Court ruling.

Of importance in future federal actions, according to FDA, is the Appeals Court's decision that testimony of lay witnesses that they had cancer, or were cured of cancer, has no value in the eyes of the court.

DIABETES DETECTION DRIVE

November 16-22

Sponsored by

The Connecticut Diabetes Association

Dr. Burdette J. Buck, president of the Connecticut Diabetes Association, has announced that plans for the annual detection drive are being developed according to county needs and facilities. The programs will emphasize education of the public concerning diabetes and the cooperation of all physicians is requested. The annual drive is endorsed by County Medical Associations and in previous years has achieved a leading place in the national program of the American Diabetes Association, with which the Connecticut organization is affiliated.

The lower trial court judge had refused to issue an injunction against the Hoxsey Clinic. After reviewing the testimony of the 50 medical witnesses and cancer experts who testified for the government, and the 25 defense witnesses, the Appeals court ordered an injunction against Harry M. Hoxsey and the Hoxsey Cancer Clinic (Dallas), prohibiting shipment of their products across state lines to cancer patients.

THE DOCTOR'S OFFICE

Louis Bernstein, M.D. announces the opening of an office for the practice of radiology at 983 Main Street, Hartford.

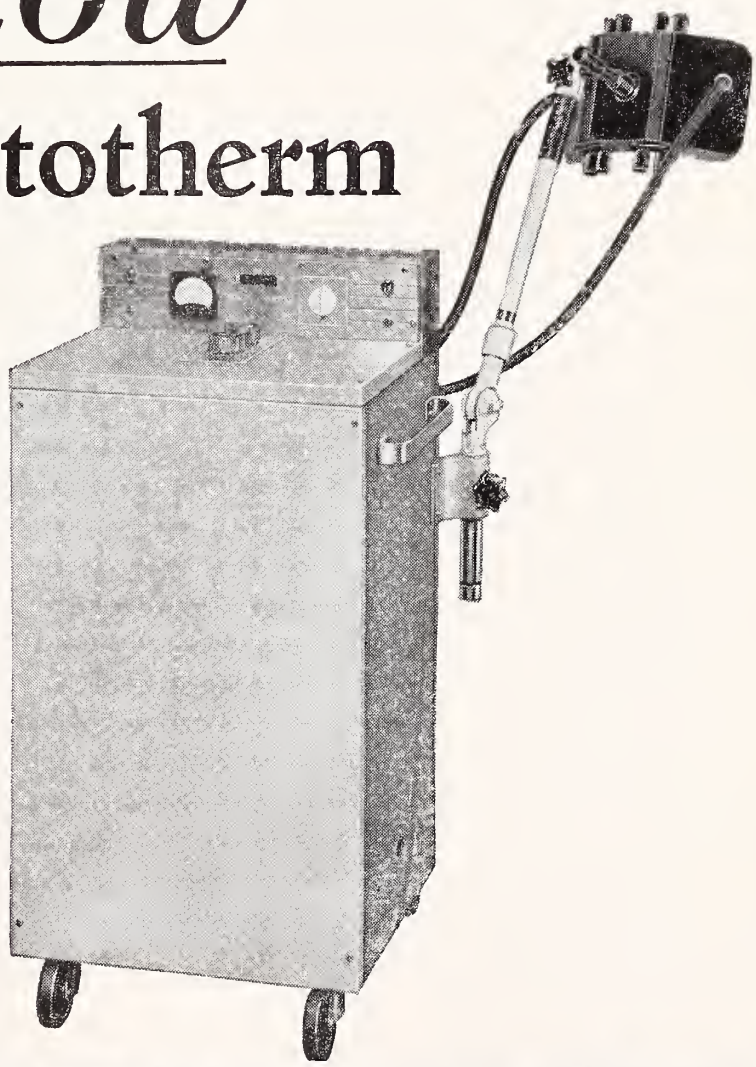
Max G. Carter, M.D. announces the opening of an office for the practice of thoracic and cardiac surgery at 3 Second Avenue, Waterbury.

Roger P. Castro, M.D. announces the opening of an office for the general practice of medicine at 10 Balmforth Avenue, Danbury.

Herbert Levine, M.D. announces the opening of an office for the practice of internal medicine at 121 Main Street, Middletown.

Alec Rabinovitch, M.D. announces the opening of an office for the general practice of medicine at South Main Street, Colchester.

You'll get a lot more out of the *all-new* GE Inductotherm



Now you can give your patients the desired quality and intensity for the full range of diathermy treatments. New GE Model F Inductotherm combines all the latest advances in induction heating therapy.

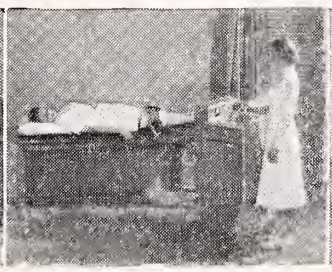
As shown in the pictures below, this handsome, trouble-free unit provides for a wide range of diathermy technics. Output has been raised to 200 watts — for most efficient utilization of induction heating methods. Unit is crystal controlled for absolute adherence to FCC-approved frequency.

Demand for the Model F is already great. To insure getting one of these great new Inductotherm units soon, call your GE x-ray representative right away. For illustrated literature, write

GENERAL ELECTRIC



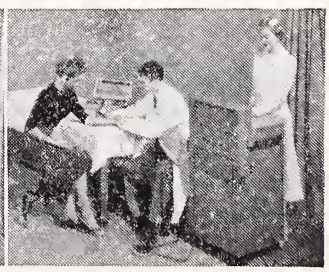
Fully adjustable contour following electrode is part of the basic unit.



Optional is the 12 ft. treatment cable. Note how electrodes attach in rear.



Also available: fully adjustable air-spaced condensor type electrode.



Surgical facilities, integral part of unit, for all medium and light technics.

Direct Factory Branch: **178 South Whitney Street, HARTFORD**

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Freeze-In of Military Doctors Troubling Them and Pentagon

A sizable number of young physicians who signed up for Army and Navy residencies in civilian hospitals in 1948 and 1949, and who were sent to Korea soon after outbreak of war there, have been frozen into uniform and cannot get out even though they have fulfilled their periods of obligated service. To get the residencies, they were required to agree to serve their active duty as Regulars, and resignations of Regulars are not being approved today because of the emergency. Some of them are willingly embarked on military careers, but majority feel Uncle Sam's end of bargain should be kept. Army-Navy medical personnel officials acknowledge they have a case and are genuinely concerned over injurious effect the situation will have on recruitment for the Regular corps. They point out, however, that if these young doctors had not taken the residencies—with full pay and allowances—they would have been brought into uniform a year or two later anyway under provisions of Public Law 779 (doctor-draft).

Rusk Committee Calls on State Chairmen to Observe Appeals Procedure

National Advisory Committee to Selective Service System (Dr. Rusk Committee) has ordered state committee chairmen to cease requesting local draft boards to delay action in the case of physicians already ordered up for induction. On this the National Advisory Committee says: ". . . the only recourse at this time is to make representation to the state (Selective Service) director . . ." If the state director declines to act, State Committee chairmen are directed not to appeal to the military service to which the registrant has been allocated, but to make a full report of the case immediately to the National Advisory Committtee for its consideration.

Because some state and local committees are bogged down with the task of processing Priority III physicians, the National Advisory Committee makes this suggestion: "For the present, until further ground rules can be laid down, the youngest in the group (Priority III) should be considered first, working up through the ages as far as is feasible with personnel available and the necessary considerations to be given to cases of Priority I and II reservists and registrants or other correspondence requiring immediate attention."

PHS Reserve Officers Must Register Under Doctor-Draft Law

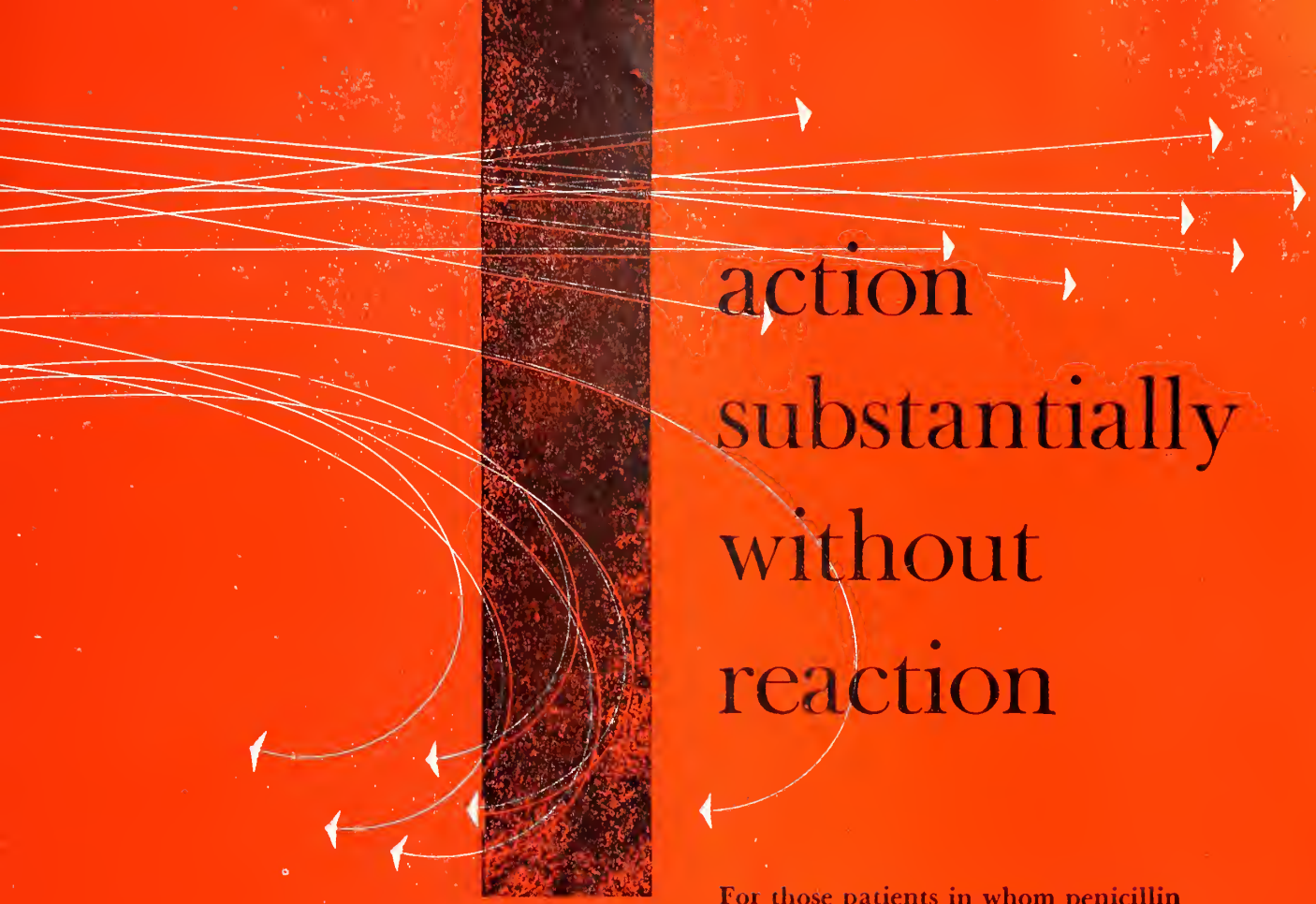
Because the last Congress did not extend the military status of Public Health Service officers, all PHS reserve physicians, dentists and veterinarians less than 51 years of age must now register with Selective Service local boards under the doctor-draft law. However, there is no change in their status. Selective Service says (a) they are not subject to induction, (b) they receive credit for service the same as the armed forces, (c) they continue to receive the $100 per month special pay, and (d) they get credit for all service after September 16, 1940.

2,038 Priority III Physicians Classified

Local draft boards on July 31 had processed 2,038 of the 32,636 physicians in Priority III. However, no callups from Priority III are anticipated until March at least. The plan is to call the younger men first. Priority III physicians are those who have had no military service, but were neither educated by the government nor deferred from World War II service to continue their education.

No Combat Pay for Doctors

Physicians and others on active duty are reminded by Defense Department that "if service personnel receive incentive or special pay for aviation, submarine, parachute, or medical or dental duty, etc., during a month, they are not entitled to combat pay



action substantially without reaction

For those patients in whom penicillin G causes sensitivity reaction, Cer-O-Cillin provides the same antibiotic action but is substantially free from side effects in most cases.

Upjohn researchers developed Cer-O-Cillin (penicillin O) by replacing the benzyl group of penicillin G with an allylmercaptomethyl group, thus making penicillin therapy available to nearly *all* patients.

For action substantially without reaction . . .

Cer-O-Cillin*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

POTASSIUM

POTASSIUM PENICILLIN O (ALLYLMERCAPTOMETHYL PENICILLIN)

**Trademark*

a product of **Upjohn Research** *for medicine . . . produced with care . . . designed for health*

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

for that month even though they had the required service with a combat unit."

Physician Quotas for October and November

Army and Air Force have asked Selective Service to draft 371 physicians and 200 dentists in October and 341 physicians and 200 dentists in November. In October the Army is to receive 196 physicians, the Air Force 175; in November 166 physicians go to Army and 175 to Air Force. A December callup is in prospect since each month witnesses discharge of hundreds of Reserve medical and dental officers who have completed active duty obligations under doctor-draft law.

The Defense Department reports that the October calls will bring the total inducted or called to active duty since July, 1951 to 1,893 physicians and 850 dentists.

With the aid of Public Law 779 the military is getting enough men for medical and dental replacements but shortage of older men, particularly experienced specialists, is starting to pinch. These latter are found chiefly in Priority III and IV and are now being classified under the doctor-draft law with callups due next April or May.

FROM OUR EXCHANGES

The January number of the *Texas State Journal of Medicine* (48.1) contains three interesting articles dealing with peripheral vascular disease. Heyer divides his material into two groups, namely, (1) diseases of deficient blood flow and (2) thrombophlebitis and phlebothrombosis. The advent of anticoagulant therapy, the development of sympathicolytic drugs and the use of antibiotic drugs has provided in his opinion effective medical measures of treating peripheral vascular disease. Raynaud's disease, Buerger's disease, sclerosis of the peripheral arteries and thrombophlebitis can usually be successfully treated by conservative medical means, provided the diagnosis is made early. Surgical therapy generally should be reserved for advanced stages of peripheral vascular disease and for serious complications.

Crump and Heiskell offer a preliminary report on the use of alpha tocopherol and calcium gluconate in the prevention of thromboembolism. In their experience the use of these drugs was effective in lowering the incidence of thromboembolic complications postoperatively. No hemorrhagic manifestations and only minimal side reactions were evidenced. The method followed in treating a large number of cases took the outline of administering to each patient on the beginning day of surgery with alpha tocopherol in the form of Epsilan Phosphate (Warren-Teed) in the amount of 100 international units every eight hours intramuscularly until the patient was able to take Epsilan Acetate (Warren-Teed), 100 to 200 international units by mouth. In addition 10 cc. of calcium gluconate was given intravenously daily for the duration of hospitalization. Antithrombin levels were determined daily.

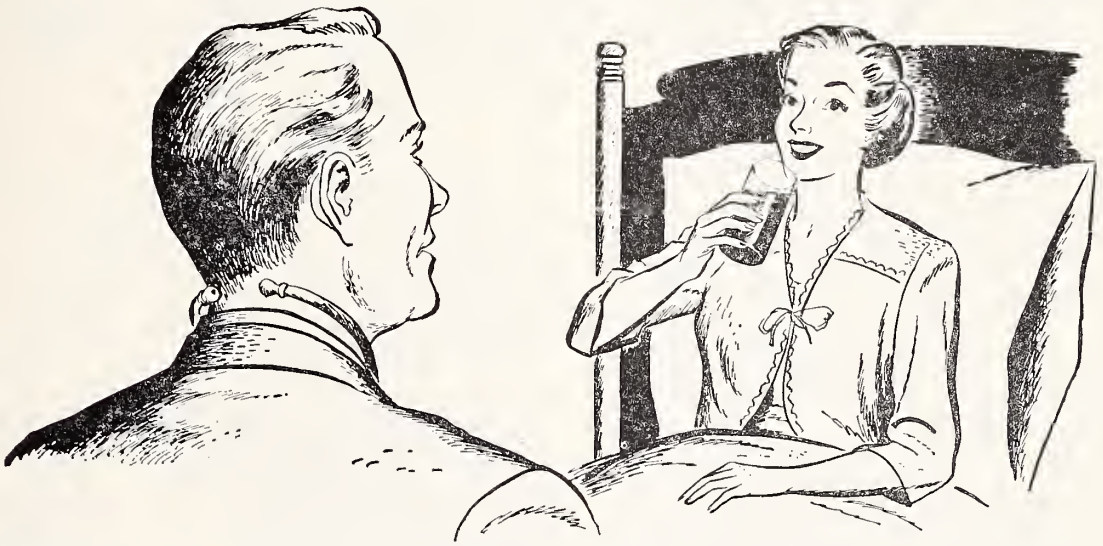
Prolonged anticoagulant therapy for ambulatory patients is considered at some length by Elster and Eisenstadt. Dicumarol was the drug that was used in their series of cases. Elster and Eisenstadt used the Link-Shapiro modification of the Quick prothrombin method in determining the prothrombin time. The test is simple and can be done in the office. Dicumarol should not be used in various blood dyscrasias, liver dysfunction, peptic ulcer, ulcerative colitis and preuremic conditions. The attending physician must be familiar with the indications, dosage, early symptoms and treatment of toxic reactions to the drug. Given intelligent use the drug can be administered with few or no toxic reactions. A patient with repeated episodes of thromboembolism can be maintained on anticoagulant therapy for years or even a lifetime. The comment is perhaps allowable that Dicumarol is a drug of infinite usefulness in selected cases, provided always that it is administered with intelligence and its effects are alertly followed through the entire period in which it is given. It is a drug that is capable of producing harmful or even fatal reactions if its effects are not followed on almost a daily basis in a competent laboratory.

* * * *

Ben N. Miller (*Jour. of South Carolina Med. Assoc.*, 48.1) considers that Bentyl Hydrochloride

WHEN DRUG THERAPY

Increases Nutrient Requirements



The administration of many drugs can sharply increase the patient's requirements for various essential nutrients. The presence and action of certain drugs in the organism may alter normal utilization of nutrients to purposes of detoxication of these drugs.

In some instances, drugs may impair absorption of nutrients, increase their destruction within the digestive tract, interfere with their metabolism, or hasten their elimination. With prolonged administration, therefore, unless the intake of various nutrients is increased, deficiency states may be precipitated.

The dietary supplement Ovaltine in milk can significantly increase the nutrient intake of the patient when therapy makes this adjustment necessary. As shown by the table below, it provides substantial amounts of all nutrients known to be essential. Its excellent quality protein furnishes an abundance of all the indispensable amino acids.

Because of its delicious flavor, Ovaltine in milk is universally enjoyed by patients. It is easily digested, bland, and its nutrients are quickly available for utilization. The two varieties of Ovaltine, plain and chocolate flavored, both similar in high nutrient content, allow choice according to flavor preference. Children particularly like Chocolate Flavored Ovaltine.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS				VITAMINS			
*CALCIUM	1.12 Gm.	MAGNESIUM	120 mg.	*ASCORBIC ACID	37 mg.	PYRIDOXINE	0.6 mg.
CHLORINE	900 mg.	MANGANESE	0.4 mg.	BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.	CHOLINE	200 mg.	*THIAMINE	1.2 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.	FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
FLUORINE	3.0 mg.	SODIUM	560 mg.	*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
*IODINE	0.7 mg.	ZINC	2.6 mg.	PANTOTHENIC ACID	3.0 mg.	*VITAMIN D	420 I.U.
*IRON	12 mg.						

*PROTEIN (biologically complete) ..... 32 Gm.
*CARBOHYDRATE ..... 65 Gm.
*FAT ..... 30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

is an improved substitute for atropine for gastrointestinal spasm. It produces its effect without dilating the pupils or drying the mouth. Kolantyl is not only well tolerated but is even more effective than plain Bentyl in the treatment of duodenal ulcer and functional bowel disease. Dr. Miller believes that the efficacy of Kolantyl is due in large measure to the inactivation of lysozyme by sodium lauryl sulfate.

* * * *

Spontaneous Hypoglycemia; The Use of a Provocative Insulin Test is a matter which is discussed by Hardwig and Schrock *(Jour. Iowa State Med. Soc.*, 42.1). In the authors' opinions spontaneous hypoglycemia of the functional type is not uncommon. Hypoglycemia is found frequently by those who search for it and rarely by those who do not. Fatigue, hyperacidity and vasomotor instability characterize these individuals. A flat glucose tolerance curve seems typical for these patients. The diagnosis is often difficult because of the bizarre symptoms that hypoglycemia produces. The treatment of a recognized case is quite simple. A diet high in proteid, low in carbohydrates (50 to 100 Gm.) and the remainder of the caloric intake furnished by fats give quite uniformly good results.

The author adds the caution that the simple term "spontaneous hypoglycemia" is no more a diagnosis than is the term "pleurisy." A precise etiological diagnosis is of vast importance because treatment of the various types is fundamentally different. A patient with organic hyperinsulism due to islet-cell adenoma will do badly on a diet that restricts the carbohydrate intake.

* * * *

An editorial in *Northwest Medicine* (51.1) discussing an audience reaction to an address delivered to medical-lay audience by Senator Taft in Los Angeles concludes with the observation that "If the audience was representative of the people, it seems possible to draw a significant conclusion. The next presidential campaign can be fought and won on the single idea of economy in government. It is of such transcending importance to the country that no other issue will seem very important."

* * * *

Acute Hospital Bed Needs as discussed by Dr. L. E. Powers et al *(Northwest Medicine*, 51.1) ends with the following conclusions: (1) If an attempt is made to reach the recommended level of 4.5 general hospital beds per thousand population, the nonprofit, nongovernmental hospitals will be in serious financial difficulties. (2) Present data on hospital usage and average patient stay would indicate that 3 beds per thousand population should not be exceeded in Washington State. (3) Federal funds for hospital construction would best be used in areas where no hospital beds exist and for institutions of special needs, such as specialized hospitals, teaching hospitals and health centers.

* * * *

"The attractive areas skim the cream of our staff, yet our need of the best type of health visitor is greater than theirs" is a complaint that is voiced in an editorial covering the needs of certain industrial areas in Great Britain. *(The Practitioner*, 1004.)

* * * *

The Physician and Rural Health is the subject of an editorial appearing in the *Journal of the Medical Association of Georgia* (41.4). The author properly calls attention to the fact that there is a difference between health and medical care. The citizen who fails to make this distinction and who fails to accept his responsibility in this respect "will forever find it impossible to obtain sufficient doctors, nurses or hospitals to assure good health." Good health is after all in the end an individual problem, for it is in the main the result of a proper diet, the installation of sanitary labor and living methods on the farm and the observation of safety measure in farm machinery operation. On analysis the key to the solution of rural health problems is education. It is important that doctors take the lead in assisting the farmer to solve his own health problems.

The comment is in order that the problem of rural health and the physician is no different in its broad outline from the same problem as it exists in the city. Illness is an individual and for the most part a private matter. Health problems, as they apply to a community, are largely a matter of education.

* * * *

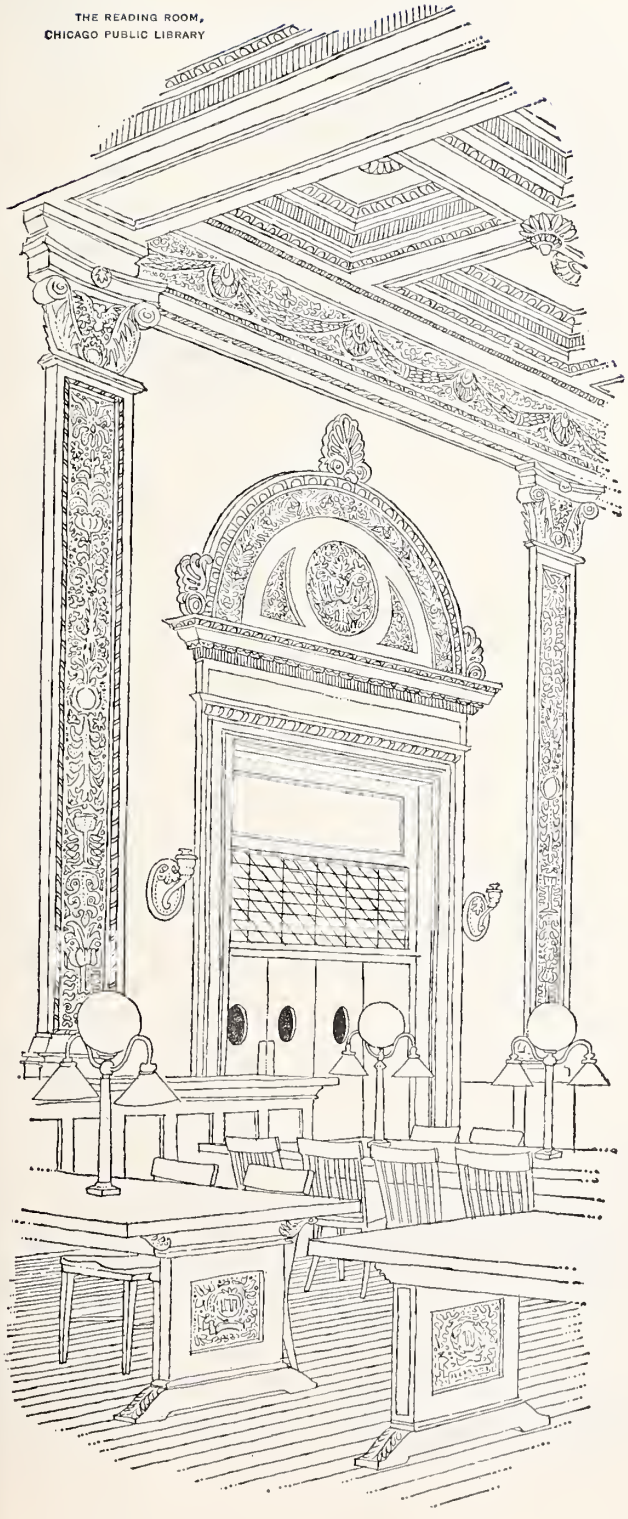
C. Dixon Fowler *(Jour. of the Med. Assoc. of Georgia*, 41.4) has compiled an excellent summary of the use of sulfa drugs and the more recent mold antibiotics in pediatrics. In a general way he has presented the indications for the use of these modern remedies and has, as accurately as possible, presented the limits of their dosage. It is on the whole a superior presentation for reference purposes of a complicated and involved subject.

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

From among all antibiotics, Ophthalmologists often choose

AUREOMYCIN

Hydrochloride Crystalline



because

Aureomycin penetrates the ocular tissues and fluids, after passing the blood-aqueous barrier.

Aureomycin in 0.5% solution is well tolerated by the conjunctiva.

Aureomycin may be used locally in appropriate solution; or by mouth; or, in emergency, intravenously; or by a combined approach, depending upon the seriousness of the infection.

Aureomycin has proved of value in a number of ocular infections in which other remedies have failed.

Aureomycin has been reported to be effective against susceptible organisms in the following conditions commonly seen by ophthalmologists:

Blepharitis
Conjunctivitis
Dendritic Keratitis
Epidemic Keratoconjunctivitis
Episcleritis
Periorbital Infection
Acute Trachoma
Uveitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100.
250 mg.—Bottles of 16 and 100.
Ophthalmic: Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
30 Rockefeller Plaza, New York 30, New York

"The Clinical Pathology of Multiple Myeloma" is the subject of an article by W. N. Powell *(Tex. State Jour. Med.,* 48.1). In a period of twenty years Dr. Powell saw 33 cases of multiple myeloma. The disease was recognized more than a century ago but it is only within recent years that it has been frequently observed. The diagnosis is today comparatively readily made as a result of a greater knowledge of its various manifestations and of improved laboratory methods. The common laboratory findings were excessively high erythrocyte sedimentation rates, anemia, hyperproteinemia, the presence of myeloma cells in the peripheral blood, Bence-Jones proteinuria, excessive rolueaux formation and hypercalcemia.

A close cooperation between the clinician, the radiologist and pathologist is emphasized in the diagnosis of this disease. Multiple myeloma in the age group beyond forty is probably more common than we realize. The comment may be added that myeloma may occur at any age, though it is a rare finding in small children.

Incomes of Physicians, Dentists, and Lawyers, 1949-51

Incomes of physicians, dentists, and lawyers continued to rise in 1950 and 1951, according to the results of three recent surveys conducted by the Office of Business Economics as part of its national income work.

Following their relative stability from 1948 to 1949, the average (mean) net incomes of lawyers and dentists increased about 10 per cent from 1949 to 1951. Physicians' incomes rose 13 per cent over the period. In 1950, the average income of physicians maintained the same moderate increase, about 4 per cent, as in the previous year, but in 1951 it advanced markedly, by 9 per cent.

These increases in professional incomes since 1949 should be considered against the background of the general rise in money incomes and prices. From 1949 to 1951 there were increases of about 15 per cent in both the over-all average earnings of employees and proprietors and in the cost of living as measured by the Consumers' Price Index.

In 1951, the mean net income of lawyers ($9,375) exceeded dentists' ($7,743) by close to 20 per cent, as was the case in 1949. The income of physicians in 1951 ($12,518) exceeded that of lawyers by one-third and that of dentists by three-fifths.

From 1949 to 1951 there was a 13 per cent increase in the mean net income of both major independent physicians—from $11,858 to $13,378—and all physicians. Similarly, the 10 per cent increase in the mean net income of all categories of dentists combined reflected primarily the 10 per cent rise (from $7,168 to $7,856) in the income of those dentists engaged in major independent practice. So too in the field of law, where those engaged entirely or mainly in independent practice upped their mean net income from $8,183 in 1949 to $8,936 in 1951—a 9 per cent increase, as in the case of all lawyers. Moreover, for each profession the year-to-year movement in the mean net income of major independent practitioners was quite similar to that of all practitioners.

During the period under analysis, net income kept pace with gross receipts for all three professions—an indication that changes in the business expenses of physicians, dentists, and lawyers engaged in independent practice were in line with those in gross receipts, and that the profit ratios of 1949 were maintained. The 1949-51 increase of almost 12 per cent in the mean gross receipts of major independent physicians corresponded closely to the 13 per cent increase in their net income. Major independent dentists increased both their mean net and gross incomes by 10 per cent, while lawyers in independent practice increased theirs by 9 per cent.

The change in income for salaried physicians and lawyers was not very different from that for independents. Physicians engaged in major salaried practice increased their mean net incomes at a slightly higher rate than did those engaged in major independent practice, both in 1950 and in 1951. For the two-year period, salaried physicians showed a total increase of 15 per cent in their average net income, as compared with a 13 per cent rise for those engaged in independent practice.

Major salaried lawyers maintained an even rate of increase in their mean net income (a little better than 4 per cent) from 1949 to 1950 and from 1950 to 1951, whereas the income of independent lawyers advanced 6 per cent in 1950 but only 3 per cent in 1951. For the two-year period, however, the mean net incomes of both independent and salaried lawyers were up by 9 per cent.

In the fields of law and medicine the proportion of salaried practitioners is considerably larger than in the field of dentistry. (Approximately 35 per cent of all lawyers and 22 per cent of physicians are



RELAXED . . . *but awake*

In the many cases which require sedation without excessive hypnosis, Mebaral is of outstanding merit.

With its relatively wide margin between sedative and hypnotic dosage, Mebaral may be employed in those conditions in which relief from anxiety, depression or agitation is desired during the waking hours.

INDICATIONS:

Mebaral affords alleviation of tension in the hyperthyroid or hypertensive patient, relaxation in neuroses and mild psychoses, a calming influence in the high-strung menopausal patient. It is also a reliable anticonvulsant in epilepsy.

Mebaral®

TASTELESS TABLETS

Tablets of 32 mg. (½ grain), 0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains)

WINTHROP-STEARNS INC., New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

engaged in major salaried practice, in contrast to only 8 per cent of dentists.) Thus, due to the comparatively small original sample, there were too few returns received from salaried practitioners in the dental survey to yield reliable data on salaried income from dentistry.

Since nonsalaried practitioners comprise a very high proportion of those engaged in major independent practice, the income movements for these two groups from 1949 to 1951 were not significantly different.

Average income data back to 1929 for these three professions are available only for nonsalaried practitioners. However, since about two-thirds of all physicians and lawyers and nine-tenths of all dentists are nonsalaried, an examination of the trend in income for this group has considerable significance for the profession as a whole.

Since 1929, physicians in nonsalaried practice have increased their mean net income by 157 per cent, as compared with 83 per cent for nonsalaried dentists and 58 per cent for nonsalaried lawyers. For perspective, it may be noted that the average earnings of all nonfarm entrepreneurs rose 144 per cent from 1929 to 1951.

Whereas long-term data covering all practitioners (not just the nonsalaried group, as discussed above) are not available for lawyers and dentitsts, such information for physicians indicates an increase of 136 per cent in their over-all average net income from 1929 to 1951. This was closely in line with the 141 per cent increase in the average income of all earners in the general population (wage and salary workers together with farm and nonfarm entrepreneurs).

The data also show that physicians have increased their gross and net incomes by about the same rate since 1929, whereas both lawyers and dentists have experienced a larger over-all increase in gross income than in net income.

The data were gathered by means of mail questionnaires sent to small cross sections of the medical, dental, and legal professions. Response was on a voluntary basis, and no weighting procedures were used to adjust the raw survey data.

Approximately 5,000 practitioners in each profession were randomly selected to receive questionnaires. The sample of physicians was chosen from files maintained by the American Medical Association of all living physicians in the United States.

Mean Gross and Net Incomes of Nonsalaried Physicians, Dentists, and Lawyers, Selected Years, 1929-51

	PHYSICIANS		DENTISTS		LAWYERS	
	(DOLLARS)		(DOLLARS)		(DOLLARS)	
YEAR	GROSS	NET	GROSS	NET	GROSS	NET
1929	8,567	5,224	7,112	4,267	7,997	5,534
1940	7,632	4,441	6,592	3,314	6,747	4,507
1947	17,742	10,726	12,032	6,610	11,498	7,437
1951	22,298	13,432	14,085	7,820	14,171	8,730
	PER CENT INCREASE					
1929-51	160	157	98	83	77	58
1940-51	192	202	114	136	110	94
1947-51	26	25	17	18	23	17

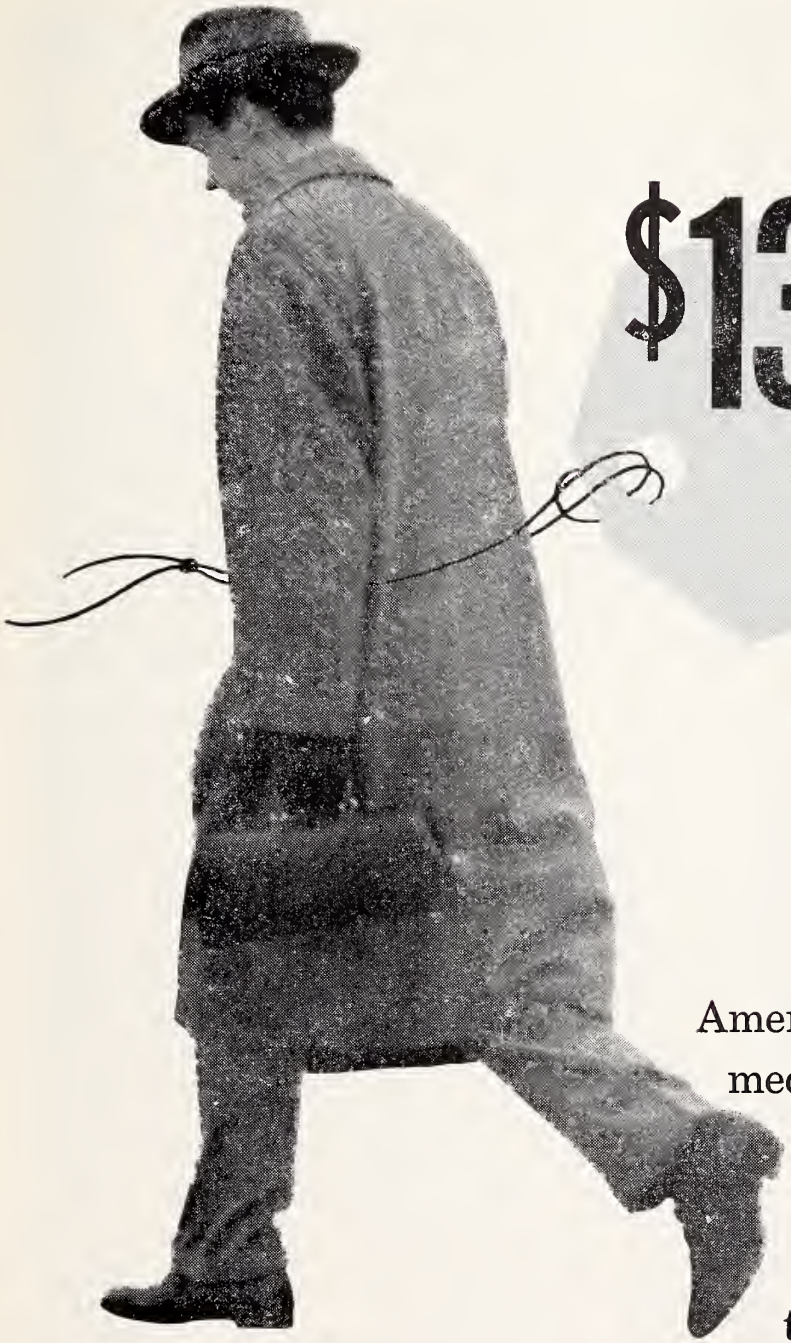
The list of lawyers was obtained through a systematic sampling, by States, of the 1952 Martindale-Hubbell Law Directory. The dentists were sampled from the membership file of the American Dental Association. In deriving the 1950-51 estimates of dental income shown in the table, it was assumed that the percentage change in the average income of dentists not members of the American Dental Association was the same as that of members.

The questionnaire forms were brief, asking only for gross income, expenses, net entrepreneurial income, salaried income, and total professional net income for the years 1949, 1950, and 1951. In addition, the legal questionnaires requested information from entrepreneurs on the number of partners and on the net income of the law firm.

A comparison of the 1949 mean net income from independent practice as determined from the interim survey and that as established by the bench-mark data—both for physicians and lawyers—showed the difference between the two to be well within the area of sampling fluctuation. Such a comparison for dentists was not possible since the level of income of ADA members is known to be significantly higher than that of nonmembers.

The *Journal of the American Medical Association*, in reviewing the findings, observed—

". . . this survey provides good bench-mark data on the incomes of physicians, a subject about which there has been a considerable amount of highly speculative writing and speaking in recent years. Thus the entire medical profession has benefited by the willingness of 55,000 of its members to cooperate with the U. S. Department of Commerce in one of the periodic surveys needed in the preparation of estimates of national income and personal consumer expenditures."



$13,356

America's
medical schools graduated
6,135 new doctors
of medicine last year.
It cost $13,356
to train each of them.

Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.

American Medical Education Foundation

535 North Dearborn Street, Chicago 10

Sterility Notes From the 1952 Chicago Conference

Inglis Frost of Morristown, N. J., presented a review of 40 cases studied over a period of six years where the primary cause of sterility was ovarian dysfunction. He emphasized the fact that the problem of diagnosis and treatment in this condition depends entirely upon the interpretation of the endometrial biopsy. The anovulatory cycle is best treated with both estrogen and progesterone. Large doses of progesterone are used sublingually in cases with a normal basal temperature chart where there is secretory arrest evidenced by proliferative endometrium. Where the cycle is short, progesterone is started as early as the first day. Small uteri are primed with stilbesterol, then followed with progesterone.

One of the most exciting discussions of the conference was presented by G. E. Seegar Jones of Baltimore. Believing that ovarian dysfunction is related to adrenal hyperplasia, she has been using low dosage cortisone (not ACTH) therapy in a group of hirsute women, without conspicuous virilism or Cushing's disease and with normal or barely elevated 17-ketosteroids and amenorrhea or oligomenorrhea. There resulted a uniform fall in the 17-ketosteroid excretion and the majority menstruated regularly following therapy. Some pregnancies occurred in women previously unable to conceive. The Cushing's syndrome group would not be expected to respond. Sturgis offered the theory that if cortisone is ineffective in the hirsute group the trouble must be in the ovaries.

Siegler of Brooklyn is still enthusiastic over the cyclic treatment of sterility due to anovulation. He starts out with ethynyl estradiol plus progesterone, then moves on, if unsuccessful, to equine gonadotropine, then to chorionic gonadotropine, irradiation, and finally surgery in that order. Many are skeptical of this program.

Bradbury and Long of Louisville, Kentucky induce and maintain decidua in the endometrium of normal women with the use of progesterone intramuscularly as crystals in aqueous solution, plus estrogen by the same route as crystalline suspensions or in oil or orally. This series of observations should provide direct evidence of the requirements of progesterone and estrogen in the early weeks of pregnancy.

Thyroid as a useful endocrine substance in the treatment of infertility is believed by Tyler of Los Angeles to be mostly a myth. He found it ineffectual in normal individuals and capable even of lowering the basal metabolic rate. This rate is not the only criterion by which one should be governed. The best judge of the effectiveness of thyroid is probably the regulation of the menses. Fertile males have been found to have a wide range in metabolic rates. Greenblatt believes that thyroid should not be used except in cases of true hypothyroidism.

Kroeger of Evanston, Illinois, co-author of Psychosomatic Gynecology published in 1951, emphasized the need for the evaluation of personality factors in all cases of sterility. His remarks were not quite as indigestible as some of the chapters of his book, in fact, much of what he said was not new but will bear repeating for the benefit of the physician who forgets that there are those cases of sterility which, when alleviated, because of physical and mental unfitness for motherhood, afford but a hollow triumph.

Charny, Merange and Conston of Philadelpia offered a preliminary report to show the discouraging results in hypogonadism treated with orchipexy. They believe the lack of descent of the testis is due to a fundamental unhealthy condition of the male organ which orchipexy does not remedy. Chorionic gonadotropin increases the development of the normal testis but has no beneficial, and sometimes a deleterious effect on the cryptorchid. It was brought out in the discussion that the operation of orchipexy should not be done because of the high incidence of carcinoma in cryptorchidism. Orchiectomy should be done in the unilateral cases; what to do in the bilateral remains a problem.

John Macleod of New York City, the recipient of the Ortho Award, as usual startled the conference with some of the results of his research work. First, he has proven that a high frequency of intercourse is more conducive to fertility than a low frequency. Second, that the duration of abstinence from coitus influences the quantity of sperm favorably but the motility unfavorably. Third, that in large numbers of the population—and he has studied 1,100 marriages—there is no relation between the semen volume and the ease of conception. He found that above a 20 million count there is no appreciable increase in the ease of conception, that there is a definite rise in the fertility potential with a rising quality of motility, that there is no relation between sperm morphology and ease of conception in large numbers of the population, and that coitus should be four or more times a week to produce the easiest conception. Some of these findings are definitely contrary to previously accepted dicta.

PROVED in three years' clinical use

Cortone®

ACETATE

(CORTISONE ACETATE, MERCK)



Typical experience:

Administration of CORTONE,
systemically, reduced rheumatoid arthritis symptoms
in *all* of 100 patients treated.
Daily maintenance doses of 50 mg. or less, orally,
were adequate in 53 per cent of cases.

Wood, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. **26**: 361, Sept. 26, 1951.

CORTONE is the registered
trade-mark of Merck & Co., Inc.
for its brand of cortisone.

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

©Merck & Co., Inc.

SPECIAL NOTICES

NEW HAVEN MEDICAL SOCIETY

1952

October 1

Claude Forkner, M.D., associate professor clinical medicine, Cornell University Medical College

October 12

Stanley Sarnoff, M.D., associate professor of physiology, Harvard University

November 5

Samuel Silbert, M.D., consulting surgeon, Mount Sinai Hospital, New York.

November 19

Richard B. Cattell, M.D., Department of Surgery, Lahey Clinic, Boston, Mass.

December 3

Charles Friedberg, M.D., Department of Cardiology, Mount Sinai Hospital, New York

December 17

Paul Reznikoff, M.D., professor clinical medicine, Cornell University Medical College

1953

January 7

Chester Southam, M.D., Sloane Kettering Institute, Memorial Hospital, New York

January 21

David Little, M.D., S. Grosskreutz, M.D., Dr. Hampton, Dr. Turner, "Problems in Anesthesia," Anesthesia Department, Grace-New Haven Community Hospital

February 4

Dean Clark, M.D., assistant director, Massachusetts General Hospital

February 18

Annual Meeting

March 4

Mark Ravitch, M.D., Department of Surgery, The Johns Hopkins Hospital, Baltimore, Maryland

March 18

Business Meeting

April 1

Open

April 15

Robert Gross, M.D., Department of Surgery, Childrens Hospital, Boston.

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

October 2

Peptic Ulcer

Dr. Chester W. Fairlie, gastroenterologist, Hartford Hospital, Hartford

October 9

Viral Hepatitis

Dr. Paul M. Sherwood, chief of medicine, VA Regional Office, Hartford

October 16

Psychosomatic Aspects of Gastrointestinal Disease

Dr. Isadore Schnap, chief of Mental Hygiene Clinic, VA Regional Office, Hartford

October 23

Radiological Aspects of Gastrointestinal Disease

Dr. George P. Perakos, gastroenterologist, New Britain General Hospital, New Britain

October 30

Chronic Ulcerative Colitis

Dr. Max Caplan, gastroenterologist, Meriden Hospital, Meriden

Meetings are held at 8:30 A. M. in the Conference Room at 95 Pearl Street, Hartford. All interested physicians are cordially invited.

ESSAY CONTEST OF ASSOCIATION OF CONNECTICUT TUMOR CLINICS

The Association of Connecticut Tumor Clinics wishes to announce the creation of a prize of $100 to be known as the Association of Connecticut Tumor Clinics Award.

1. The prize will be awarded each year for the best paper on Cancer submitted by any licensed physician in the state of Connecticut.

2. Preference will be given to those papers relating to the results of treatment for Cancer based on studies utilizing the tumor records of the Connecticut Hospitals.

3. Any paper already presented for publication during the year preceding March 1, 1953 may be submitted.

4. All entries must be sent to the Cancer Coordinating Committee of the Connecticut State Medical Society on or before March 1, 1953. The final award will be announced at the annual meeting of the Society.

5. The prize paper will be published in the Connecticut State Medical Journal.

Announcing



A new film in full color

Special Problems in the Management
of
PEPTIC ULCER •
by
Department of Gastroenterology
of the Lahey Clinic

A Unit of the Wyeth Peptic Ulcer Service

Among the topics developed are: esophageal ulcer; gastric ulcer, benign and malignant; postbulbar ulcer and subtotal gastrectomy for intractable ulcer in the descending portion of the duodenum; pyloric obstruction; hemorrhage; postoperative jejunal or anastomotic ulcer. 16 mm., color with sound, 30 minutes. To obtain this film for group showing, write to:

FILM LIBRARY
WYETH INCORPORATED
1401 Walnut Street
Philadelphia 2, Pa.

- *FILMS*
- *LITERATURE*
- *MEDICATION*

Wyeth®

WYETH PEPTIC ULCER MEDICATION

Amphojel®, N.N.R. (Aluminum Hydroxide Gel, Alumina Gel)—For the medical management of gastric and duodenal ulcer; or for the control of symptomatic gastric hyperacidity.
Amphojel without Flavor, N.N.R.
Amphojel Tablets N.N.R. (Dried Aluminum Hydroxide Gel, Hydrated Alumina Tablets, 0.3 Gm. (5 grains); 0.6 Gm. (10 grains).
Phosphaljel®, N.N.R. (Aluminum Phosphate Gel)—for marginal ulcer.

HARTFORD HOSPITAL
GUEST SPEAKER PROGRAM
Saturdays 11 A. M., Hartford Hospital Amphitheater

October 4

Sidney Farber, M.D., pathologist, Children's Hospital, Boston, Massachusetts, and director of Research, Children's Cancer Research Foundation

Recent Advances in Treatment of Disseminated Cancer

October 11

Harold M. Marvin, M.D., associate professor of Clinical Medicine, Yale University School of Medicine

Recent Advances in Cardiac Management

October 18

S. J. Thannhauser, M.D., emeritus professor of Clinical Medicine, Tufts College Medical School

Case Presentations

October 25

Speaker to be announced

November 1

J. Lawrence Pool, M.D., professor of neurosurgery, Columbia University College of Physicians & Surgeons. The Neurological Institute, Presbyterian Hospital

Neural Structures of the Mind

November 8

L. Corsan Reid, M.D., professor of experimental surgery, Postgraduate Medical School, New York University

Local Tissue Hormones

November 15

Joseph J. McDonald, M.D., professor of surgery, Columbia University College of Physicians & Surgeons

The Role of Reconstructive Surgery in the Management of Cancer of the Head and Neck

November 22

Professor H. Olivecrona, Stockholm, Sweden

Neurosurgical subject to be announced

November 29

Edward Scull, M.D., former Fellow in Clinical Research, Bellevue

Intra-articular Treatment with Hydrocortisone

December 6

Averill A. Liebow, M.D., professor of pathology, Yale University School of Medicine

Clinical Pathological Conference

December 13

Lester Adelson, M.D., department of pathology, Western Reserve University School of Medicine

The Role of the Pathologist in Homicide Investigation

December 20

J. William Littler, M.D., assistant attending surgeon and consultant in Hand Surgery, Roosevelt Hospital, New York City

Problems of Reconstructive Surgery of the Hand

December 27

No clinic

SYMPOSIUM
INDUSTRIAL INJURIES
to the Spine, Shoulder, Hand, and Knee
St. Mary's Hospital Auditorium, School of Nursing, Waterbury, Connecticut, October 9, 1952

Under the auspices of Industrial Health Committee, State Medical Society.

Sponsored by The American Brass Company, Waterbury, Connecticut.

The purpose of this symposium is to clearly define the various disabilities of the back, shoulder, hand and knee as to their causal connection with industrial workers arising out of, and in the course of their employment, with particular emphasis upon—

a. primary injuries, as sole factors in the production of disability.

b. aggravation of a pre-existing condition resulting in a permanent, partial, or total disability.

c. the precipitation of a dormant factor resulting in a partial or permanent disability.

d. acceleration of a pre-existing pathological entity.

The sessions will be open to all physicians and surgeons interested in compensation work throughout the state and to insurance companies; to the Connecticut Manufacturers Association, the Connecticut Personnel Association and the safety organizations of the state.

1:30 P. M. Differential Diagnosis and Treatment of Industrial Disabilities of the Back.
David M. Bosworth, M.D., New York, N. Y., director, Department of Orthopedic Surgery, and attending orthopedic surgeon, New York Polyclinic Medical School and Hospital, and St. Luke's Hospital.

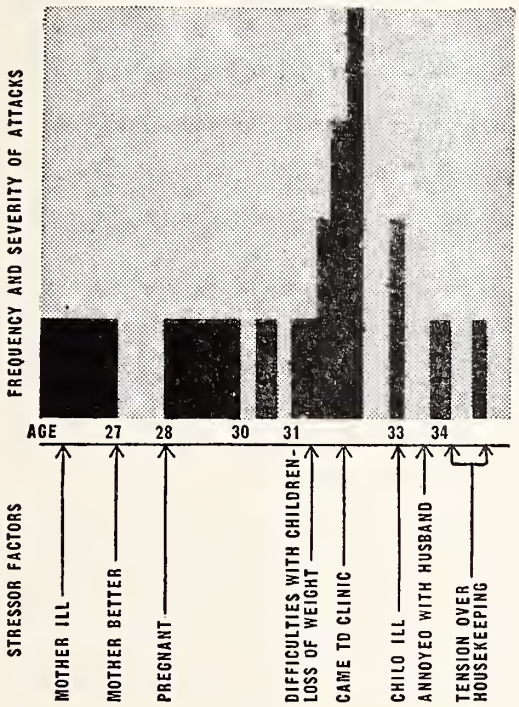
2:30 P. M. Shoulder Injuries in Industry.
Anthony F. DePalma, M.D., Philadelphia, Pa., professor, head of Department of Orthopedic Surgery, and chief orthopedic surgeon, Jefferson Medical College Hospital.

3:30 P. M. Hand Injuries in Industry.
J. William Littler, M.D., New York, N. Y., attending surgeon, Roosevelt Hospital, Plastic and Reconstructive Surgery; instructor in surgery, Columbia University; consultant in hand surgery to the Surgeon General, Valley Forge Hospital.

4:30 P. M. Knee Injuries in Industry.
Alphonso Della Pietra, M.D., Waterbury, Conn., assistant attending orthopedic surgeon, New York Poly-

Stress . . .

Stressor factors which evoke autonomic responses occur often in our civilization. They are not always of external origin, frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world."[1]



After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. *4*: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

Incessant "emotional buffeting" impinged on labile autonomic pathways is likely to produce deviations from normal body function and *a rash of symptoms.* In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are: belladonna alkaloids, ergotamine tartrate and phenobarbital. These drugs may be used individually or in combination,* as required by the individual case, to effect more stable function of the autonomic nervous system, thereby "dampening" overactivity of the involved organ systems.

* Dosage of each ingredient adjusted to the needs of the particular patient.

[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

In very special cases
A very superior Brandy



Specify 84 Proof

★ ★ ★

HENNESSY
THE WORLD'S PREFERRED
COGNAC BRANDY
Schieffelin & Co., New York N.Y.

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years,* are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

Medical Technician desires position in Hospital Laboratory or doctor's office in or around New Haven area. Had one year college, two years training at Graduate Hospital of University of Pennsylvania. Also three years working experience. Write to: E.W.M. c/o CONNECTICUT STATE MEDICAL JOURNAL, 160 St. Ronan Street, New Haven, Conn.

Professional Office in Manchester. Excellent location for doctor or pediatrician. Entire suite now being air-conditioned. Contact T. J. Crockett Agency. Phone Manchester 5416.

Unusual offering East Haddam, Conn. Forty-three acres within easy reach of Connecticut River. Twenty-eight rooms; eight baths; ten fireplaces; oil-o-matic air conditioning heating plant; large studio living room; all parquet floors. Botanical gardens with fountain, imported shrubs. Everything in A-1 shape. Could not be duplicated for $250,000. One of Connecticut's outstanding scenes of beauty. Act quickly. Full price $37,000. Terms can be arranged. Write Fred Donath, 17 Bluff Avenue, West Haven, Conn.

clinic Medical School and Hospital, and St. Luke's Hospital, New York City; associate attending orthopedic surgeon, St. Mary's Hospital, Waterbury.

6:00 P. M. Cocktails at the Waterbury Country Club.

7:30 P. M. Dinner for speakers, members of the Industrial Health Committee and invited guests. Pleasure of the American Brass Company.

Address of Welcome, Mr. A. H. Quigley, chairman of the Board, The American Brass Company.

Speaker of the evening: Dr. Maurice Frocht, associate attending neurologist, Presbyterian Hospital, New York; associate neuropsychiatrist, Lenox Hill Hospital, New York.

Subject: Psychosomatic Problems in Industrial Workers Influencing Industrial Workers' Health and Accident Prevention.

Guest speakers will meet at the Hotel Elton where rooms will be reserved.

Luncheon will be held at the Hotel Elton at 12 noon for speakers and for the Compensation Commissioners of the State of Connecticut and invited guests. Pleasure of the American Brass Company.

PARKING

Space will be provided at St. Mary's Parochial School diagonally across from the main hospital entrance.

HARTFORD HEART ASSOCIATION COURSE ON CARDIOVASCULAR DISEASE—1952

HYPERTENSION—NEWER ASPECTS OF TREATMENT

Robert W. Wilkins, M.D., associate professor of medicine, Boston University School of Medicine, Boston, Massachusetts. Hunt Memorial Building, 38 Prospect Street, 8:00 P. M., Friday, October 3, 1952.

ARTERIOSCLEROSIS OF CORONARY VESSELS—PRESENT STATUS

John H. Heller, M.D., chairman, Section of Medical Physics, Yale University School of Medicine, New Haven, Connecticut. Friday, October 10, 1952.

INFECTION AND CARDIOVASCULAR DISEASE

Paul B. Beeson, M.D., Ensign professor of medicine, Yale University School of Medicine, New Haven, Connecticut. Friday, October 17, 1952.

PERICARDITIS

Clarence E. de la Chapelle, M.D., professor of medicine, New York University Post Graduate Medical School, New York, New York. Friday, October 24, 1952.

RHEUMATIC HEART DISEASE AND PREGNANCY—THE IMMEDIATE AND REMOTE PROGNOSIS

Harold Gorenberg, M.D., attending physician and chief of the Cardiac Clinic, Margaret Hague Maternity Hospital, Jersey City, New Jersey. Friday, October 31, 1952.

NEUROCIRCULATORY ASTHENIA (ANXIETY NEUROSIS, NEURASTHENIA, NERVOUS EXHAUSTION)

Mandel E. Cohen, M.D., director, Laboratory for Investigation of Neurocirculatory Asthenia and Allied States, Massachusetts General Hospital, Boston, Massachusetts. Friday, November 7, 1952.

AMA CLINICAL SESSION, DECEMBER 2-5

Many at A.M.A. headquarters are now busy with plans for the annual Clinical Session which will be held in Denver's newly-enlarged Municipal Auditorium, December 2-5.

Physicians are urged to make their reservations as soon as possible. A page advertisement, carrying the advance registration form and the hotel reservation request, will appear in the A.M.A. Journal each week, beginning with the issue of August 23.

The meeting will open Tuesday morning, December 2, with the scientific exhibit, medical motion pictures, the technical exposition and registration. Tuesday afternoon colored television will be shown, with general lectures in the main auditorium, followed by clinical presentations in eight meeting rooms adjacent to the technical and scientific exhibits.

The scientific exhibit will be held on the lower level of the new building, adjacent to four of the meeting rooms. About 60 exhibits will cover a wide range of medical subjects. Manikin demonstrations will be given at stated times on the problems of delivery. One exhibit will cover fractures of the spine, wrist and ankle. Demonstrations on artificial respiration will use the new back-pressure arm-lift method.

Clinical presentations include nearly 200 lectures on obstetrics, pediatrics, diseases of the chest, cardiovascular diseases, neurology and psychiatry, fluid balance and kidney problems, traumatic surgery, and medical therapy. In addition, outstanding guest speakers from various parts of the country will lecture on hypertension, bone tumors, urinary infections in children, methods of parenteral protein feeding, and other basic subjects.

Colored television will originate from Denver General Hospital and will bring the operating room directly into convention hall.

The technical exposition on the arena floor will be located adjacent to the registration desks and two of the meeting rooms.

Restaurant facilities in the auditorium will make it possible for physicians to attend a full day of activities without leaving the building.

A diversified entertainment program is being planned for each evening.

VOTE
NOVEMBER 4



New 2-Way Aid in ACNE

Now hide and treat acne blemishes simultaneously with new AR-EX R.M.S. Lotion. Complexion tinted. Contains resorcinol monoacetate and sulphur in gentle AR-EX Foundation Lotion. Non-astringent.

AR-EX COSMETICS, INC., 1036 W. Van Buren St., Chicago 7, Ill.

Send for Free Sample.



AR-EX R.M.S. Lotion

Anemia

Although there are many repeat donors in the Connecticut Regional Blood Program, yet the need for recruitment of new donors is pressing as the demand for blood exceeds our supply. It is, therefore, somewhat depressing for our volunteer recruiters to be told that "my doctor does not think I should give blood because I have anemia."

The Program is very stringent in its protection of donors. A hemoglobin estimation is done on every prospective donor at the time of every donation. Persons, either male or female, who have a hemoglobin estimation of less than 12.5 Gms. as determined by the copper sulphate technique of Phillip and Van Slyke are not permitted to give blood. This is not only a requirement of the National Institutes of Health, but is also consistent with good medical practice.

Let us, as physicians, when asked about the advisability of donating blood, reassure our patients that they will not be permitted to donate if there is any indication of anemia.

NEWS
from County Associations

Hartford

Wilmar M. Allen, M.D. director of the Hartford Hospital, has been appointed to the VA Special Medical Advisory Group by Joel T. Boone, chief medical director of VA Department of Medicine and Surgery.

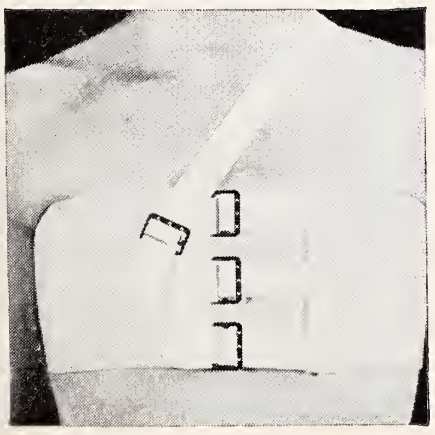
* * * *

Frederick L. Nichols, Sophie A. Root, Charles S. Mirabile and R. Starr Lampson are the authors of "Cushing's Syndrome Treated by Removal of Adrenal-Cortex Tumor," published in the *New England Journal of Medicine.*

* * * *

George R. Andrews is the new head of the Mental Hygiene Clinic at the Hartford Hospital. Dr. Andrews recently completed a three year residency at Yale in psychiatry. He has opened an office in Hartford for the practice of psychiatry.

* * * *



ELASTIC RIB BELTS FOR FRACTURED RIBS

More comfortable and efficient than adhesive strapping
Made of the finest quality elastic webbing

Quantity	Size	Price
	Large Adult	$2.75 ea.
	Adult	$2.50 ea.
	Medium Adult	$2.25 ea.
	Child	$2.00 ea.

LITTLE MFG. CO.
Box 202
WADESBORO, N. C.

Order through your Dealer, or order direct with this ad.
Delivered
Less 10% on orders of 12

SHIP TO:

_____
_____
_____

HOW YOU CAN HAVE "social security"

To most people, Social Security means the Government program of old age and survivors' insurance. Social security (without capitals) may also be obtained in other ways — for example, by the private pension plans of many industrial companies.

For doctors and other people in the professions, however, neither the Government program nor industrial pensions are usually available. Most of them must build their social security through savings, investment and life insurance. But, all too often, they lack the time to establish and supervise a coordinated plan which makes the best *use* of such resources.

Why Not a Living Trust or an Investment Management Account?

To assist you in setting up a sound program for reaching *your* particular goal, we suggest that you consider establishing a Living Trust, with the Hartford National Bank and Trust Company as Trustee, or engaging us as your agent to advise you in regard to your investments. A trust agreement would, of course, be drawn by your own lawyer. Any one of our Trust Officers will be glad to review with you and your attorney suitable arrangements based on this Bank's experience in the management of many trust and investment accounts.

Why not stop in, telephone, or write our Trust Department, *now?*

Hartford National Bank and Trust Company

Established 1792

Main and Pearl Streets, Hartford

Member Federal Deposit Insurance Corporation

Arthur F. Ells, former justice of the State Supreme Court of Errors, will be be the guest speaker at the 160th semi-annual meeting of the Hartford County Medical Association. Mr. Ells is now a state referee since his retirement from the upper court in 1949. Previous to that he was a judge in the Superior Court from 1923 to 1940. He is now a director of the Institute of Living in Hartford, a trustee of the Litchfield Mutual Fire Insurance Company, and a member of the society of alumni of Amherst College, the American Law Institute, the American Bar Association and the Connecticut Bar Association.

During his career he was a former prosecutor for the United States district court, a former judge of probate, a member of the Connecticut senate and chairman of its judiciary committee from 1923 to 1925, and chairman of the Connecticut Highway Safety Committee from 1941 to 1947.

* * * *

HCMA honored Ralph B. Cox last month for fifty years of medical practice. William H. Upson, president of the county, presented Dr. Cox with a plaque noting his outstanding service to the community. The presentation was made at the Canton High School on Sunday, September 21 during a four hour reception given to Dr. Cox by the people of Collinsville.

* * * *

At its September meeting HCMA's board of directors heard Joseph L. Gordon, county executive secretary, outline his two day visit to the AMA Public Relations Institute held in Chicago, September 4 and 5. Mr. Gordon said, "This first meeting was excellently arranged and programmed. All the speakers—executive secretaries of county and state associations, professional public relations counsels and AMA officers—had practical and useful things to say. I came away with the feeling that this was a real 'meat and potatoes' meeting. Certainly the AMA should plan more meetings of the same type."

Middlesex

Mark Thumim was in Portland, Maine from June 21 to September 6, where he attended the Lancaster Courses in Ophthalmology.

Don't Be a Part-Time Citizen

REGISTER! — VOTE!

Table of Contents : November 1952

Five Year Study of Maternal Mortality and Morbidity in Connecticut—1946-1950, Inclusive — Carl E. Johnson, M.D., New Haven 809

Cancer of the Larynx in General Practice — Jocelyn S. Malkin, M.D., and John A. Kirchner, M.D., New Haven 816

Pre-Employment Medical Examinations to Select—Not Reject — Leslie W. Foker, M.D., Minneapolis 822

Twenty-Five Years of Surgery in a Small Hospital — Karl T. Phillips, M.D., Putnam 826

Health of the World's Children (Childhood in the Old World and the New) — Martha M. Eliot, M.D., Washington, D. C. 829

EDITORIALS

Specialism and the Intern Year 835
Diabetes Week 836
The World's Children 836
Connecticut Story 836
Blue Cross Rates and Stabilization 836
Connecticut First 837
Salute to Texas 837

DEPARTMENTS

Progress in Clinical Medicine
Tularemia in Connecticut
John A. Woodworth, M.D., Moosup 838
The President's Page 842
The Secretary's Office 843
Public Relations 854
News From Washington 858
Military Affairs 860
Letters to the Editor 861
From Our Exchanges 864
Woman's Auxiliary 866
New Books in Review 874
Our Neighbors 880
News From County Associations 880

MISCELLANEOUS

Connecticut Plan for Medical Care of Veterans 845
The Medical Examination in School Health Service
Edwin R. Van Kleck, PH.D., New York 850
The Doctor's Office 856
Special Notices 869
Contributors to American Medical Education Foundation (as of October 2, 1952) 876

Be Sure to Vote!



The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI NOVEMBER, 1952 No. 11

A FIVE YEAR STUDY OF MATERNAL MORTALITY AND MORBIDITY IN CONNECTICUT — 1946-1950, INCLUSIVE

CARL E. JOHNSON, M.D., *New Haven*

SINCE Connecticut is a small State and since there are too few maternal deaths to justify a committee on maternal mortality in each city, the Connecticut State Medical Society realized that a state wide committee might serve the purpose. Therefore, on November 8, 1946 the Council of the Connecticut State Medical Society, acting on a recommendation received from the Committee on Public Health, appointed a permanent Committee on Maternal Mortality and Morbidity for the Society. Joseph H. Howard, who at that time was one of the obstetrical members of the Public Health Committee, was appointed as temporary chairman with Eric H. Blank, Carl E. Johnson, Norman Margolius, Charles H. Peckham, as members of the new committee. The first meeting of the Committee on Maternal Mortality and Morbidity was held on November 29, 1946. Later other obstetricians were appointed to the committee so that now there are 10 members, 8 of whom are certified by the American Board of Obstetrics and Gynecology; many of whom are chiefs of the obstetrical division of the respective hospital staffs on which they serve, and one member is a physician employed by the Bureau of Maternal and Child Hygiene of the Connecticut State Department of Health.

FORMATION AND FUNCTIONS OF COMMITTEE

The members of the committee were chosen from different areas of the State so that as far as possible the entire State might be represented. A physician employed by the State Department of Health gathers data on each maternal death occurring during pregnancy or within three months of delivery in the State. This physician talks with the attending physician on the case and with the consultants, if any, reviews the hospital record, and whenever possible obtains copies of autopsy reports and staff discussion of the case. In this process a special study form is used. From the data on the study form an abstract of the case record is prepared and copies of the abstracts are sent to the members of the committee for review at a regular meeting. As this material is confidential, the patient's name and the names of the hospital and of the physicians concerned are omitted from the abstracts, and the cases are identified by hospital record numbers and dates.

The committee meets approximately once a month, except during July and August, and reviews the cases presented. Occasionally more data is needed before the committee can decide as to the cause of death, and the attending physician may be asked to present his case to the committee. Usually such physicians are glad to attend the meeting and discuss the case with the obstetricians there. Occasionally a case may be referred to the Committee on Anesthesiology for its opinion or a qualified expert such as a cardiologist or an internist may be asked for his opinion.

The committee decides whether or not the death was attributable to maternal causes and whether or not it was preventable. If preventable, the committee tries to determine by whom and how it might have been prevented. Occasionally a letter is sent over the chairman's signature from the committee to an attending physician who has requested an opinion. A letter may also be sent by the committee to the chief of the obstetrical staff of a hospital making recommendations as to staff organization and regulations. Three or four times a year cases which may be instructive are presented at open meetings which may be attended by any interested physician. Special conferences are also held for the students of the School of Medicine of Yale University. On request the chairman of the committee may discuss with

the physicians concerned the findings of the committee on an individual case.

FALLING MATERNAL MORTALITY RATE

In the conclusion of a report* on maternal mortality covering the six years, 1940 through 1945, Joseph H. Howard had called attention to the exceptionally low rate of 1.0 maternal deaths per 1,000 live births, and made this statement:

"Cooperation by the State Health Department, hospitals and physicians can make it possible to reduce this rate to 0.5 per 1,000 live births within the next five years."

How well this prediction has been realized is shown by the 1950 rate of 0.4 per 1,000 live births. The trend of maternal mortality in Connecticut has been downward since 1933 when the rate was 5.9 per 1,000 live births to a low of 0.4 in 1950.

The present study covers the years 1946-1950, inclusive, and shows what has been accomplished during these years. Table 1 and Chart 1 present in graphic form the downward trend in deaths from maternal causes since 1926. The national rates have also been plotted on Chart 1 for comparison with the Connecticut rates.

As shown by Table 1, maternal mortality for Connecticut dropped from 6.2 per 1,000 live births in 1926 to 0.4 in 1950, a decline of more than ninety per cent. If the 1926 rate had prevailed during 1950, 251 mothers would have been lost instead of the 18 who died—a saving of 233 lives for the year 1950 alone.

Table 1

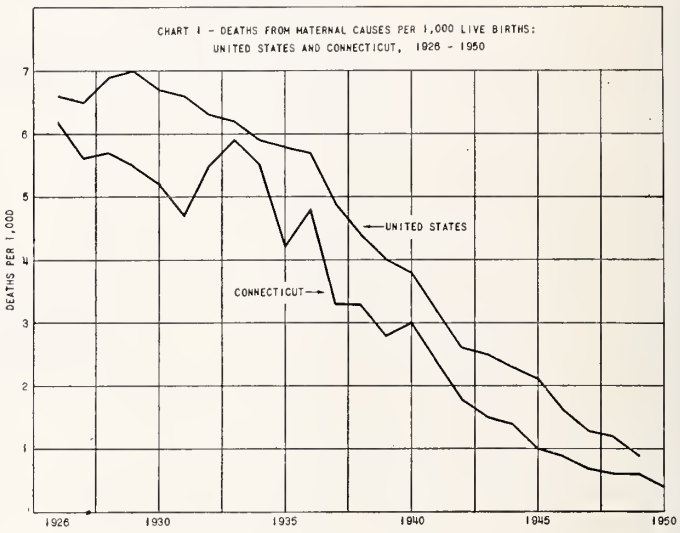
Maternal Deaths and Death Rates Per 1,000 Live Births: Connecticut, 1926-1950

YEAR	NO.	RATE	YEAR	NO.	RATE
1926	182	6.2	1938	78	3.3
1927	164	5.6	1939	66	2.8
1928	162	5.7	1940	75	3.0
1929	150	5.5	1941	69	2.4
1930	144	5.2	1942	66	1.8
1931	120	4.7	1943	58	1.5
1932	132	5.5	1944	48	1.4
1933	133	5.9	1945	35	1.0
1934	122	5.5	1946	37	0.9
1935	94	4.2	1947	32	0.7
1936	107	4.8	1948	26	0.6
1937	76	3.3	1949	26	0.6
			1950	18	0.4

Based on data from Bureau of Vital Statistics, Connecticut State Department of Health

*The preceding study of maternal mortality was published in the March 1948 issue of the Connecticut State Medical Journal and covered the six year period, 1940 through 1945. For the purposes of this study it is felt that the validity is reduced very little by the resulting comparison of unequal time periods.

The State and national rates have followed approximately the same downward trend with Connecticut in the lead. As the Connecticut rates approach an irreducible minimum, the rate for the country as a whole is also closer to this goal. The



sixty per cent reduction in maternal mortality shown in the present study has been due largely to an increasing awareness among obstetricians that many of the deaths occurring among maternity patients were preventable, and that better obstetrical procedures might have prevented many of these deaths.

METHODS AND PROCEDURES

The present paper intends to outline the findings of the present study for the five year period, 1946-1950, and to compare these results with similar findings based on the deaths occurring during the six year period, 1940-1945. To facilitate comparison with other studies conducted in the field, all deaths in Connecticut which involve pregnancy were classified using the International List of Causes of Death. Although the Sixth Revision of the International List did not come into general use until 1949, all deaths which came before the committee for the five year period, 1946-1950, were classified using this Revision. Similarly, the death study during the period 1940-1945 was classified according to the earlier Fifth Revision. Studies conducted by the New York State Department of Health and by the National Office of Vital Statistics to determine the

comparability of leading causes of death using both revisions showed little difference in results.

During the five year period, 1946-1950, 139 deaths were classified as maternal and 48 additional deaths where pregnancy was mentioned on the death certificate fell into the classification of nonmaternal deaths. During the earlier six year period the number of deaths coming before the committee were classified as 321* puerperal deaths and 54 nonpuerperal deaths.

NONMATERNAL MORTALITY CASES

In the list of nonmaternal deaths there are a good many medical conditions which are adversely affected by pregnancy. Among the more typical of these are those conditions affecting the heart. An example of this is Item VII of the list of deaths from nonmaternal causes, showing diseases of the mitral valve, other diseases of the heart specified as rheumatic, hypertensive heart disease with arteriolar nephrosclerosis, and pulmonary embolism and infarction. The list of deaths from nonmaternal causes shown below is arranged according to the new International List of Causes of Death, Sixth Revision, 1948:

List of Deaths from Nonmaternal Causes

	NO OF DEATHS
I. Infective and parasitic diseases	
002 Pulmonary tuberculosis	2
010 Tuberculosis of meninges and central nervous system	1
080 Acute poliomyelitis	2
II. Neoplasms	
170 Malignant neoplasm of breast	1
174 Malignant neoplasm of uterus, unspecified	1
175 Malignant neoplasm of ovary, fallopian tube, and broad ligament	1
190 Malignant melonoma of skin	1
193 Malignant neoplasm of brain and other parts of nervous system	1
196 Malignant neoplasm of bone	1
IV. Diseases of the blood and blood-forming organs	
292.1 Acute hemolytic anemia	1
VI. Diseases of nervous system and sense organs	
330 Subarachnoid hemorrhage	1
331 Cerebral hemorrhage	2
332 Cerebral embolism and thrombosis	1
VII. Diseases of the circulatory system	
410 Diseases of the mitral valve	2
416 Other diseases of the heart specified as rheumatic	11
442 Hypertensive heart disease with arteriolar nephrosclerosis	1
465 Pulmonary embolism and infarction	1
VIII. Diseases of the respiratory system	
490 Lobar pneumonia	1
492 Primary atypical pneumonia	1
IX. Diseases of the digestive system	
550.1 Acute appendicitis with peritonitis	1
560 Hernia of abdominal cavity without mention of obstruction	1
572.2 Ulcerative colitis	2
X. Diseases of the genito-urinary system	
590 Acute nephritis	1
592 Chronic nephritis	1
600 Infection of kidney	1
XIV. Congenital malformations	
754.3 Congenital malformations of circulatory system (interauricular septal defect)	1
XVI. Symptoms, senility and ill defined conditions	
795 Ill defined and unknown causes of morbidity and mortality	2
XVII. Accidents, poisonings, and violence	
E890 Accidental poisoning by utility (illuminating) gas	1
E921 Inhalation and ingestion of food causing obstruction or suffocation	1
E972 Suicide and self-inflicted poisoning by gases in domestic use	1
E974 Suicide and self-inflicted injury by hanging and strangulation	1
E978 Suicide and self-inflicted injury by jumping from high place	1

*The figure of 321 maternal deaths studied by the prior committee does not agree with the total shown in Table 1 for the same period because the assignment of cause of death by the committee was made with additional information made available by the survey. The figures given by the Bureau of Vital Statistics were compiled from the information given on the death certificates and included out-of-state deaths of Connecticut residents.

CAUSES OF MORTALITY

Mortality according to causes of death for 1940-1950 is presented in Table 2 and a comparison of the two study periods is shown graphically in Chart 2.

Table 2

Maternal Death Rates* by Principal Causes of Death: Connecticut, 1940-1950

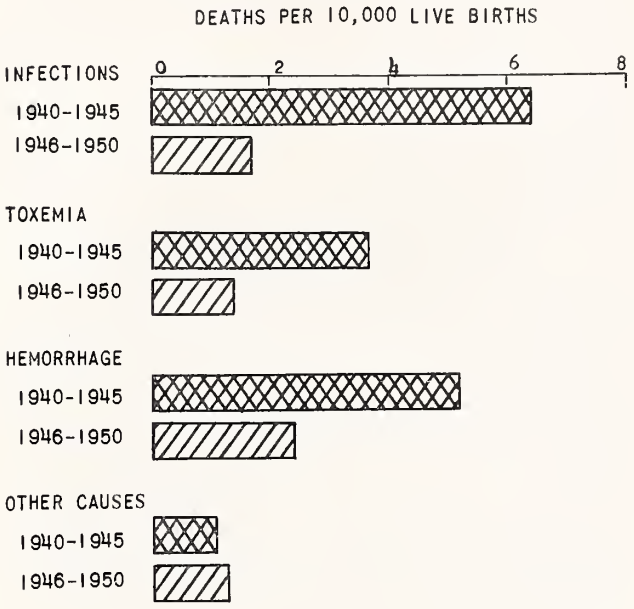
YEAR	INFECTIONS	TOXEMIAS	HEMORRHAGE	OTHER CAUSES
1940	11.8	7.0	8.2	0.8
1941	10.0	3.9	5.4	1.1
1942	5.8	3.9	6.7	0.8
1943	5.8	3.4	4.0	0.8
1944	5.5	2.7	4.6	1.5
1945	2.5	2.8	4.3	0.9
1946	1.9	1.7	3.9	1.6
1947	2.4	2.0	2.0	0.9
1948	1.7	1.2	2.1	1.2
1949	1.0	1.2	3.2	0.7
1950	1.5	1.0	0.8	1.3

*Deaths are per 10,000 live births

The steady reduction in deaths due to infection received a new impetus with the introduction of the more recently discovered antibiotics and the continued use of the sulfonamides so that the decline in the past five years has been quite precipitous.

CHART 2 - MATERNAL DEATHS BY PRINCIPAL CAUSE:

CONNECTICUT, 1940-1945 AND 1946-1950



The average annual rate for deaths from hemorrhage for the years 1946 through 1950 was 2.4 per 10,000 live births. This category offers the greatest possibility for decreasing the Connecticut rate still further. The fact that in 1950 the unusually low rate of 0.8 per 10,000 was reached leads to the belief that this hope is attainable. Credit must be given to the vigilance of the individual physicians and nurses as well as increased use of transfusions and better knowledge of the matching and proper cross matching of blood.

There has been a slight rise in deaths from "other causes." Included among deaths from other causes were: anesthesia (1 ectopic) 5; abortion 2; air embolism (one of which was also abortion) 2; pulmonary embolism 1; pulmonary edema 2; influenza 2; aspiration vomitus 1; postpartum psychosis 2; intestinal obstruction 1; acute myocarditis 1; acute ventricular dilatation 1; paralytic ileus 2; natural causes undetermined 1. With increased knowledge more of the deaths from these causes may become preventable. This is especially true of those deaths in which anesthesia may have been responsible. At the suggestion of the Committee to Study Mortality and Morbidity, a committee has been appointed by the Council of the Connecticut State Medical Society to study anesthetic mortality and morbidity in the State.

In reference to Table 3 it will be noted that there are few cases of version or version-extraction. Except in the case of twins or other multiple births, Cesarean section has a lower mortality and morbidity than version and extraction. The number of instances of deaths occurring under the heading high or midforceps is also decreasing. Again Cesarean section is now the operation of choice in those cases which formerly would have been delivered by high forceps. Forceps are now considered useful only in cases where the head has reached at least the midplane of the pelvis. In this series of cases, 1946-1950, there was only one in which high forceps were used.

TABLE 3

TYPE OF DELIVERY BY PRINCIPAL CAUSE OF DEATH: CONNECTICUT, 1940-1950

PRINCIPAL CAUSE	TOTAL		CESAREAN SECTION		VERSION, VERSION-EXTRACTION		HIGH OR MID FORCEPS		OTHER OPERATION		INAPPLICABLE	
All causes	1940-45	1946-50	1940-45	1946-50	1940-45	1946-50	1940-45	1946-50	1940-45	1946-50	1940-45	1946-50
Number	321‡	139	70	24†	19	5	21	8	48	24	163	78*
Per cent	100	100	21.8	17.4	5.9	3.6	6.8	5.8	14.9	17.2	50.3	56.0
Infections	126	36	25	5	3	0	7	0	22	6	69	25
Toxemias	73	30	12	3	1	3	9	2	9	5	42	17
Hemorrhage and shock	103	50	33	7	15	2	5	6	16	10	34	25
Other causes	19	23	0	9	0	0	0	0	1	3	18	11

*Includes 39 with no operation and 39 undelivered

†Includes 16 first and 8 repeat cesareans.

‡Based on findings of the survey of 1940-45

Table 4 illustrates the point that the obstetrical risk increases with increasing age of the mother and shows that older people need earlier and more intensive prenatal care.

Table 5 shows a reduction in deaths with twenty-four or more hours of labor with a breakdown into type of delivery. One is impressed by the absolute and relative reduction in the number of deaths occurring after a labor of twenty-four hours or more. Better management of cases involving operative procedures has resulted in the reduction in the number of deaths in which Cesarean section and long labor are associated. The committee has repeatedly emphasized the hazard of too long a trial of labor before deciding to operate. How long to wait is often a matter of the keenest obstetrical judgment. Adequate use of antibiotics and the maintenance of proper metabolism by parenteral fluids and blood are imperative in patients with long labors. As a result of these improved methods of treatment, patients are better able to withstand continued labor or prove to be much better operative risks if operation becomes necessary.

Consultation in an obstetrical abnormality, no matter how simple, is compulsory in the better hospitals. These consultations may be rendered gratis by the members of the obstetrical department when so indicated.

HOME DELIVERIES

At the present time less than one per cent of deliveries in the State of Connecticut occur in the home and therefore this factor is no longer of any importance in influencing maternal mortality. Only 0.9 per cent of deaths during the last five years followed domiciliary delivery as contrasted with a figure of four per cent for the preceding six years.

PREVENTABLE DEATHS

Although the mortality rate has reached the low level of 0.4 the committee is of the opinion that this figure can be reduced still further. There are still a number of deaths which might be prevented. This is shown in Table 6 and Chart 3, which illustrates the number of deaths during the five year period that were considered preventable and also the number not preventable.

Hemorrhage—Among those cases which were classified as preventable (in part) by the attending physician, twenty-seven were due to hemorrhage. That deaths from hemorrhage can be reduced has been proven by a drop in the number of cases from sixteen at the beginning of the present five year study to three in 1950. (This in spite of a greater number of deliveries). The importance of early diagnosis of hemorrhage and its type is obvious in order that prompt and appropriate treatment may be instituted. In instances of severe hemorrhage prompt transfusion to fully replace lost blood must not be delayed. However, an attempt to completely replace blood while hemorrhage persists should not be allowed to delay operative procedures aimed at controlling the hemorrhage itself. All too frequently death has occurred while waiting for the patient's

Table 4

Maternal Deaths According to Age of Mother: Connecticut, 1940-1945 and 1946-1950

	1940-1945*		1946-1950	
		Average annual rate per 10,000		Average annual rate per 10,000
Age	No.	live births	No.	live births
All ages	321*	13.8	139	6.7
Under 15 years	0	0.0	0	0.0
15-19 years	12	10.9	2	2.1
20-24 years	56	8.2	25	4.3
25-29 years	81	10.2	41	5.8
30-34 years	89	18.5	31	6.8
35-39 years	59	28.8	27	13.6
40 and over	24	62.2	13	28.8

*Based on findings of the survey of 1940-1945

Table 5

Type of Delivery According to Length of Labor: Connecticut, 1940-1945 and 1946-1950

	Hours of labor							
	Total reporting†		Under 3 hours		4-23 hours		24 hours or over	
Type of delivery	1940-1945	1946-1950	1940-1945	1946-1950	1940-1945	1946-1950	1940-1945	1946-1950
Total No.	207	89	69	36	99	47	39	6
Spontaneous	64	31	18	7	40	23	6	1
Operative	138	57	49	28	58	24	31	5
Cesarean	59	21	35	18	14	1	10	2
Forceps	51	24	3	3	34	19	14	2
Other	28	12	11	7*	10	4	7	1
Undelivered	5	1	2	1	1	0	2	0

*Includes 2 abortions

†Omitted are 114 cases 1940-1945 and 50 cases 1946-1950 where length of labor is unknown

condition to improve before commencing the operation.

During the years 1945-1950 the committee has been instrumental in encouraging the establishment of blood banks in all maternity hospitals in Connecticut which was achieved by the end of 1949. The use of Rh typing and blood grouping has increased and should become as routine a procedure as the prenatal blood test for syphilis (in many cases it is being done when serology is done). To avoid delay in treatment of cases of hemorrhage, Type O, Rh negative blood should be on hand at all times so that there need be no delay occasioned by waiting for typing and cross matching of blood.

Toxemias—At the present time the only successful treatment of the toxemias of pregnancy is prophylaxis. More complete and more intelligent prenatal care is of the greatest importance. However, there frequently comes a time when prompt termination of the pregnancy becomes imperative and the most critical judgment is needed in the proper timing of delivery as well as the choice of method to be employed. Indeed, the problem may be so difficult that more than one consultation may become necessary.

The choice of the proper oxytoxic during the third stage of labor in suspected cases of toxemia or eclampsia is always important. Since pituitrin contains a vasopressor factor, it should be replaced by pitocin in all such problems.

Infections—In addition to a substantial decrease in morbidity, the antibiotics have reduced the number of deaths from infection. There is, however, danger that overconfidence in the effect of antibiotics may lead to carelessness in the use of aseptic techniques. There is also need of education of the public to seek treatment earlier, especially in cases of abortion, whether spontaneous or induced. The value of the prophylactic use of antibiotics in all instances of potential intrauterine infection cannot now be questioned. Examples of this are:

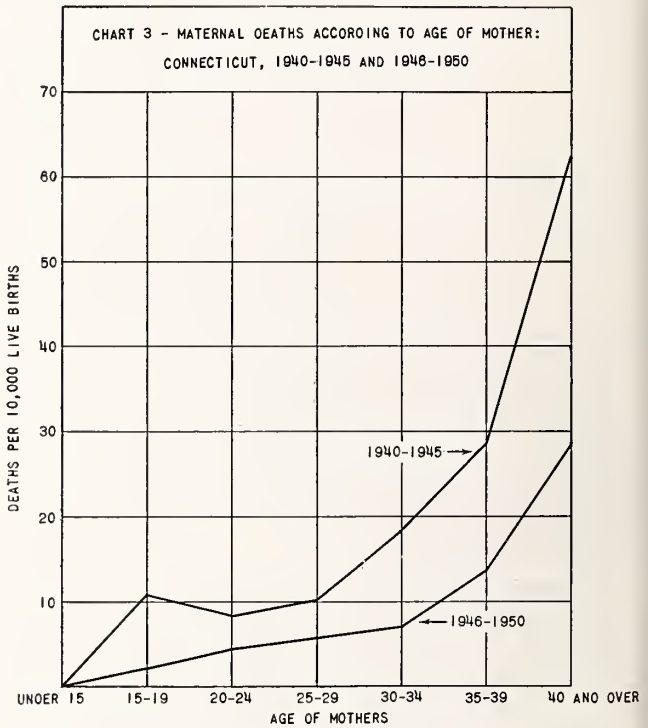
1. Premature labor.
2. Prolonged labor.
3. Trial of labor.
4. Spontaneous abortion.

Table 6

Maternal Deaths Reported as Preventable or Non-preventable According to Cause of Death: Connecticut, 1946-1950

Cause	Total	Non-preventable	Preventable		
			By physician	By patient	Inapplicable*
All causes	139	70	45	20	4
Infection	36	22	4	10	0
Toxemia	30	21	6	1	2
Hemorrhage	50	16	27	5	2
Other	23	11	8	4	0

*Includes 3 in which responsibility could not be determined and 1 where there was a lack of available blood for transfusion



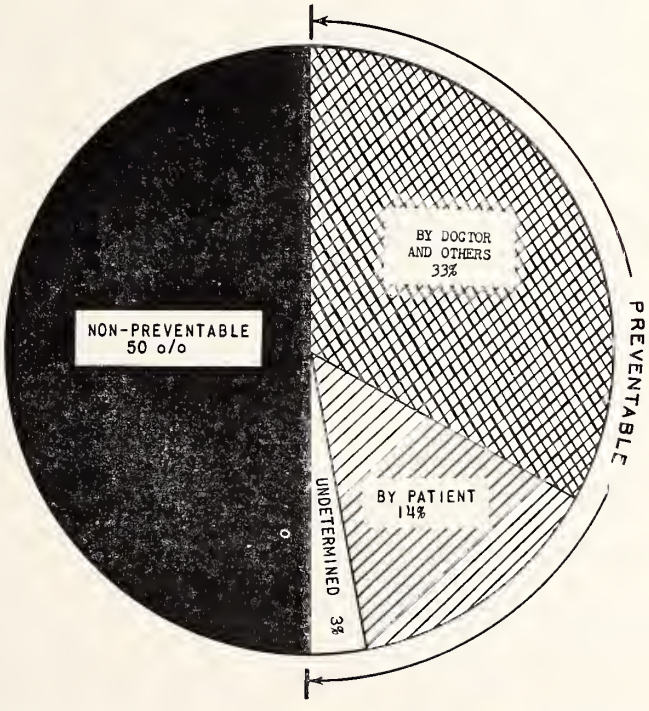
Analgesia and anesthesia—Pain relief in obstetrics continues to be a perplexing problem, and one which, unfortunately, continues to contribute significantly to the incidence of maternal mortality and morbidity. The problem is the more complicated in that the infant, as well as the mother, may suffer ill effects from obstetrical analgesia and anesthesia.

It is the experience of this committee that the dangers of overdosage of analgesic and anesthetic drugs, the possibilities of idiosyncrasy to such drugs in individual cases, the threat of vomiting and aspiration in the patient with a full stomach, and the urgent necessity for a selective choice of anesthetic agents and methods in the presence of the various complications of pregnancy are very real problems that must be recognized and dealt with by all those practicing obstetrics. The trained anesthesiologist

can render real service in helping to solve these problems, and consultation and teamwork between the obstetrician and anesthesiologist is of concrete value in attempting to reduce maternal morbidity and mortality. At the request of the Committee on Maternal Mortality and Morbidity, the State Medical Society appointed a special committee of anesthesiologists who study all deaths, including maternal deaths, in which anesthesia may have been a factor in the fatal result.

Heart Disease—The pregnant cardiac or hypertensive patient must be made to understand and accept

CHART 4 - MATERNAL DEATHS ACCORDING TO PREVENTABILITY: CONNECTICUT, 1946-1950



the necessity of submitting to a competent appraisal of her functional cardiovascular status very early in pregnancy, so that the risk of childbearing may be assessed and proper corrective or protective measures may be taken in ample time. Moreover, she should be willing to remain under regular observation in this regard throughout the pregnancy, at delivery, and for at least several months thereafter. Close collaboration between the patient, the obstetrician and the internist will go far toward preventing cardiovascular catastrophies related to pregnancy.

Preventable by Patient—In the better education of the patient lies the ony hope of reducing mortality classified as "preventable by patient." Of a total of twenty deaths so classified, five were due to hemorrhage, four of them associated with abortion. Two patients were in extremis when first seen by a physician, one an instance of rupture of the uterus and the other of rupture of the bladder. Ten deaths "preventable by patient" were due to postabortal sepsis, the majority probably self induced or criminal. One is probably justified in being pessimistic as to the value of education of the patient in this latter group. However, it would seem that in some instances the individual physician has failed in his duty to impress on the patient the value and importance of his ministrations so that his advice has been disregarded and his patient has failed to return. In this regard one wonders whether or not the physician who has once seen the pregnant woman does not have some responsibility to make sure that she does get further care, either from himself or another physician.

List of Deaths from Nonmaternal Causes: Connecticut 1946-1950

	Number of Deaths
I. Infective and parasitic diseases	5
II. Neoplasms	6
IV. Diseases of the blood and blood-forming organs	1
VI. Diseases of nervous system and sense organs	4
VII. Diseases of the circulatory system	15
VIII. Diseases of the respiratory system	2
IX. Diseases of the digestive system	4
X. Diseases of the genito-urinary system	3
XIV. Congenital malformations	1
XVI. Symptoms, senility and ill defined conditions	2
XVII. Accidents, poisonings, and violence	5
Total	48

SUMMARY

The first Maternal Mortality Committee of the Connecticut State Medical Society began to function in 1946.

A previous study covering 1940-1945, inclusive, revealed a State maternal mortality rate of 1.0 per 1,000 live births. The rate in this later study covering 1946-1950, inclusive, was found to reach 0.4 per 1,000 live births in 1950.

In this study 139 deaths were classified as maternal and 48 additional deaths as nonmaternal.

Among the nonmaternal deaths, diseases of the circulatory system claimed the largest number.

The mortality rate from hemorrhage has shown a steady fall but offers possibility of further improvement.

Because of the problems posed by analgesic and anesthetic drugs, a Committee on Anesthesiology has been appointed by the State Medical Society.

Cardiac patients require close collaboration between the patient, the obstetrician and the internist.

Further education of the patient is needed to reduce the number of deaths preventable by patient.

The Committee makes six specific recommendations.

FOR FURTHER PROGRESS IN REDUCTION OF DEATHS

Through the careful study and analysis of case histories and the exchange of ideas by the different members of this committee, great strides have been made in ways and means for reducing the maternal death rate. Although the rate has reached an almost incredibly low figure, the work of this committee must still go on until maternal deaths have reached the irreducible minimum and must continue in order to keep the figure at the lowest possible level. Accepting this responsibility, the committee advocates:

A. Continued education of the patient and physician to the value of early and adequate prenatal care;

B. A thorough study and analysis of maternal morbidity by the medical staff of each hospital;

C. Improved medical staff organization in all hospitals;

D. Written rules and regulations to assure optimum medical care for all obstetrical patients;

E. Earlier and more frequent use of consultation for medical or obstetrical complications of pregnancy;

F. Accurate and complete records on all maternity patients.

CREDIT

The writer is deeply indebted to several members of The Department of Health of the State of Connecticut, as well as to the other members of the Committee to Study Maternal Mortality and Morbidity for valuable assistance in preparing this report.

CANCER OF THE LARYNX IN GENERAL PRACTICE

Jocelyn S. Malkin, m.d., and John A. Kirchner, m.d., *New Haven*

During a recent analysis of 235 cases of cancer of the larynx seen at New Haven Hospital over the past thirty years (1921-1951) certain rather striking factors in the incidence, etiology and diagnosis of the disease appeared, and seemed to be of sufficient interest to the general practitioner to warrant this separate publication.

INCIDENCE

Whereas 94 cases were seen during the twenty year period, 1921-1940, 136 cases were seen during the past ten years, 1941-1950. The significance of this 40 per cent increase is not entirely clear. It may be the result of an absolute increase in incidence as Jackson[1] has claimed, or a function of more frequent clinical diagnosis of the disease.

RACE, RELIGION AND ETHNIC GROUPS

These appear to have no influence on the incidence of the larynx, following the general distribution throughout this area.

AGE AND SEX

In 65 per cent of the cases the age at onset was between fifty and seventy, with 34 per cent in the sixty to seventy age range. The predominance of cancer of the larynx in the male is well known, constituting about 90 per cent of all cases in reported series.[1-6] In the present series of 235 patients, 217 were male, constituting a 12:1 ratio. Females tend to get the disease at a somewhat earlier age than males.[7,8] In the present study, whereas the peak age at onset for 67 per cent of the males was between

From the Otolaryngology Section, Yale School of Medicine and The Tumor Registry, Grace-New Haven Community Hospital

fifty and seventy, 61 per cent of the eighteen women had first symptoms between forty and sixty years of age. In Orton's series, laryngeal malignancy was most common in women between the third and fourth decades.[9]

SEX AND SURVIVAL

It is interesting to note that 50 per cent of the women patients followed for at least five years survived five years or more, while only 28 per cent of the men followed for a similar period lived that long. Although 95 per cent of our cases were of the squamous cell variety in agreement with other series, thirteen lesions were of other types (sarcoma, melanoma, adenoma, etc.) and five of these appeared in women. To put it another way, 27 per cent of the female patients in our series had lesions other than epidermoid carcinoma as compared to 4 per cent of the male cases.

PREDISPOSING FACTORS

Many factors have been felt by various authors to predispose the human larynx to malignancy.[10,11] Foremost among these are 1, family history of cancer; 2, excessive use of alcohol; 3, excessive use of tobacco; 4, industrial exposures; 5, infection including systemic syphilis and tuberculosis; 6, septal deviation; 7, excessive voice use; 8, hyperkeratosis of the larynx; 9, leukoplakia; and 10, male sex.

FAMILY HISTORY OF CANCER, MULTIPLE TUMORS

In the present series of 235 cases, 13 per cent give a history of cancer in one or more members of their family. In addition to these patients, some twenty-four other (10 per cent) showed evidence of, or subsequently developed other neoplasms. In only one-third of the cases were these benign.

ALCOHOL

Our estimate of the number of patients with an excessive alcoholic intake is probably not an accurate one for several reasons: (1) alcoholic patients frequently deny excess; (2) the patient is often not specifically asked about alcoholic intake and (3) reliance had to be placed on other person's interpretation as to what constituted moderate or excessive intake. In addition, general deterioration of the chronic alcoholic, poor diet, etc., undoubtedly play an important role. Only those patients whose intake was labeled "excessive" or admitted to more than three beers or two highballs or two whiskey shots per day for an extended period of years were included. There were 69 patients, or 34 per cent, who drank excessively (one of these was a woman).

TOBACCO

The extensive use of the cigarettes began about 1918, with a tremendous increase in the manufacture and sale. In the United States last year, on an average, every person smoked 118 packs per year, or more than six cigarettes per day. The increased incidence of cancer of the respiratory tract has been related by some authors to this great increase.[12] The responsible carcinogenic agent is believed to be arsenic which is present in minute amounts in cigarette paper and in the insecticides used on tobacco plants.[12] In determining the number of patients who smoked or chewed excessively, the same problems existed as in determining those who drank a great deal. All smokers have not been included.

Persons whose chewing or smoking (pipes, cigarettes and cigars) habits were labeled "excessive," or who smoked a pack of cigarettes or more a day for ten or more years, were included. One hundred one cases or 43 per cent smoked or chewed to excess; of these, two were females. Many more were "moderate" smokers and were not included. Jackson,[1] in one series, found that 95 per cent of his cases used tobacco. The use of tobacco has been reported to be much less extensive in the general population. In a control group of 780 persons Graham[12] found only 19 per cent who smoked excessively.

INDUSTRIAL AND OCCUPATIONAL FACTORS

The relationship between industrial exposure and cancer of the respiratory tract has been the subject of considerable speculation. In a series of 857 proved cases of bronchogenic carcinoma of the lung, Graham[12] found that 5 per cent were hot metal workers and 6 per cent were painters. In this series, metalworking was the occupation in which the largest single group was engaged. Fifty-four cases, or 23 per cent of the patients, were metalworkers of one type or another. This figure might be even higher if the occupations of all the patients were known. (See Table 1.) Metalworking occupations mentioned included tool and die makers, machinists, foundry workers, molders, metal polishers, gunsmiths, silver plating, file working, sheet metal work, blacksmith work, needle making, rolling, forge working (hot metal), smelting, metal pressing, steel hardening and iron cutting.

Many men had worked for prolonged periods at their jobs. In other cases the exact duration of employment could not be determined from the hospital records.

TABLE 1

SIGNIFICANT OCCUPATIONS IN 235 CASES OF CANCER OF THE LARYNX

OCCUPATION	NO. OF CASES	PER CENT
Metal workers	54	23.0
Tool and die makers	5	
Machinists	9	
Foundry workers	11[1]	
Moulders	4	
Metal polishers	7[2]	
Gunsmiths	3	
Other	15	
Occupations associated with oil, grease and tar	16	6.8
Truckers	8	
Gas station attendants	2	
Mechanics	2	
Greasers	2	
Printers	1	
Roofers	1	
Factory workers (work unknown)	12	5.1
Farmers	9	3.8
Rubber workers	6	2.6
Hatters	5	2.1
Woodworkers	5	2.1
Stone workers (coal (2), cement, quarry[3])	4	1.7
Housepainters[4]	2	0.8
Tobacco workers	2	0.8
Brewers	2	0.8
Cotton mill worker	1	0.43
Miscellaneous	83	
Occupation unknown	34	

[1]Nine were employed in a brass foundry; one worked in an iron foundry and had a concurrent pneumoconiosis.

[2]One was a woman, one worked for 35 years polishing iron with an emery wheel, one polished silver for 26 years.

[3]Had a pneumoconiosis, had worked in a quarry 35 years.

[4]One had a lead line.

These workers were exposed[13] to iron, brass, silver fumes and dust, heat, petroleum oils, benzine (gasoline), ultraviolet and infra-red (especially foundry workers), lead, zinc, pryidine—all proven irritants of respiratory mucous membrane.

Occupations associated with oil, grease, tar and benzine (gasoline) made up the next largest group. These totaled 6.8 per cent of all occupations (known or unknown). Truckers, gas station attendants, mechanics, greasers, printers and roofers were included in this category.

Factory workers whose specific job was not known made up another 5 per cent. Some of the remaining occupations listed in Table 1, each of which made up less than 4 per cent of the total, are of interest. The exposures involved were varied and included rubber, arsenic (in insecticides), silica dust, lead, benzine (gasoline), heat, organic dust, mercury, methyl alcohol, sulfuric acid, acetone, amyl acetate, aniline, antimony, arsenic, benzol, chromium, lead, methanol, nitrous fumes, turpentine, nicotine, cold and dampness, formaldyhyde, hydrofluoric acid, phenol and sulfuric acid.[13] Without exception, all of these are considered marked irritants of the respiratory mucous membrane.[13] It is of interest that benzine (gasoline) is an irritant with which almost all of the occupations mentioned were associated.

Some eighty-three patients gave occupations which are not associated with significant exposures. These include housewives, policemen, salesmen, businessmen, and others. No occupation was listed in thirty-four cases or 14 per cent.

It might be mentioned here that six cases had x-ray evidence of a pneumonoconiosis—one of these had anthracosis. Fifteen cases or 6 per cent had pulmonary fibrosis diagnosed by x-ray.

PREDISPOSING INFECTION

Acute and chronic infection has been thought by several investigators to play a key role in the pathogenesis of cancer of the larynx. Menetrier[14] suggested that metaplasia initiated by infection was the first step in the development of malignancy.

Table 2 summarizes the acute and chronic infections found to be associated in this series with cancer of the larynx. The relative importance of these as predisposing factors can be ascertained from Figure 1. It should be pointed out that, in many instances a single patient had several of the conditions listed in

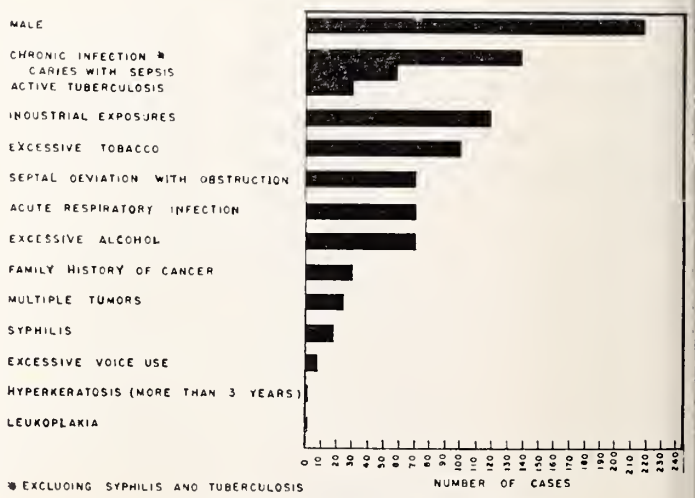


FIG 1 INCIDENCE OF PREDISPOSING FACTORS IN 235 CASES OF CANCER OF THE LARYNX

Table 2

Acute and Chronic Infection Associated With Cancer of the Larynx

	No. of cases	Per cent
ACUTE		
Upper respiratory tract infection preceding onset	23	9.8
Pneumonia at onset	17	7.2
Past history of pneumonia	17	7.2
Influenza 1918	13	5.5
CHRONIC		
Syphilis	15	6.4
Tuberculosis (active and inactive)	71	30.2
Sinusitis	9	3.8
Chronic tonsillitis	12	5.1
Chronic rhinitis	7	3.0
Post nasal drip	6	2.6
Chronic otitis	3	1.3
Frequent severe URI's	11	4.7
Frequent sore throats	1	0.4
Chronic bronchial asthma	4	1.7
Chronic cough (cause unknown)	7	3.0
Bronchiectasis	5	2.1
Pulmonary emphysema	59	25.1
Marked caries—alone	110	46.8
—with oral sepsis	58	24.6
Chronic laryngitis (more than three years)	15	6.4

Table 2. The list of chronic infections reveals several interesting and rather surprising bits of information. Thirty per cent of the cases had some form of tuberculosis. Of these, 47 per cent were of the fibrocalcific variety, 34 per cent had active pulmonary lesions, 11 per cent had merely primary Ghon foci, and 6 per cent had tuberculous lymphadenitis. There was not a single case, however, of tuberculous laryngitis although this condition was frequently erroneously diagnosed before cancer of the larynx became manifest. The same applied to syphilis of the larynx, of which not a single case was discovered.

Oral hygiene might conceivably play a part in carcinogenesis. The effect of a constant stream of infected saliva upon the larynx has to be considered. In this connection it was found that markedly carious teeth were present in one hundred ten or 47 per cent of patients and another 25 per cent had oral sepsis in addition to the caries. Other chronic infections of the air passages as listed above make one speculate upon their possible role in squamous metaplasia. The work of Winternitz in 1920 is of interest in this connection.[15]

While tabulating our data we were struck by the frequency with which nasal obstruction, as a result of septal deviation, was noted. Although we had not initially considered listing it as a possible etiological factor, it occurred so frequently that we decided to include it with predisposing factors. It has been demonstrated that an increase in the flow of air through one nostril, produced by closing the other surgically, results in squamous metaplasia of the columnar epithelia of dogs and rabbits.[16] This metaplasia is proportional to the impact of the unwarmed, dry air. In both the dog and rabbit the turbinates on the open side hypertrophy and undergo a squamous metaplasia. It is not inconceivable that similar changes could occcur in the epithelium of the larynx and lower respiratory tract. With this in mind, we tabulated the cases in which deviation of the nasal septum with obstruction was noted. In many cases it was not mentioned—in others, described only as "intact." Where deviation was noted, the presence or absence of obstruction was often not recorded. Nevertheless, seventy-three patients or 31 per cent of the cases were noted to have septal deviation with obstruction. In six of these, obstruction was bilateral and the additional factor of mouth breathing with resultant drying of air immediately comes to mind. These figures, although limited in scope and accuracy, are suggestive and have served as a stimulus to further investigation in our laboratory.

EXCESSIVE VOICE USE

In this series only seven patients or 3 per cent used their voices excessively. The figure is rather difficult of evaluation but this factor does not appear to be of significance.

HYPERKERATOSIS AND LEUKOPLAKIA

Hyperkeratosis and leukoplakia are known to be premalignant lesions. There was only one instance of each recorded before the discovery of laryngeal cancer. In many instances, however, hyperkeratosis was present histologically alongside epidermoid carcinoma at the time of diagnosis. This might indicate that mirror examinations of the larynx were not performed as frequently and as early as they should have been for the discovery of precancerous or early lesions.

SEX

The predominance of laryngeal cancer in the male is well demonstrated by the 12:1 ratio found in this series. Many theories have been advanced to explain this predilection relative to tobacco, alcohol, indus-

trial irritants, etc. It is perhaps significant that of the eighteen women in this series, one was an alcoholic, two had chronic tonsillitis, one worked for many years as a silver polisher, one made emery wheels, worked in a rubber factory and smoked to excess. Other possibly predisposing factors in these women included chronic sinusitis and septal deviation in one, septal deviation and multiple tumors in another, preceding upper respiratory tract infection in one, septal deviation alone in two, and three had a family history of cancer.

SYMPTOMS

Patients usually complained of more than one symptom. Table 3 lists symptoms in descending order of frequency.

TABLE 3
PRESENTING SYMPTOMS IN ORDER OF FREQUENCY

SYMPTOM	NO. OF CASES	PER CENT
Hoarseness	189	80.5
Cough	101	43.0
Decreased general vigor (including weight loss, anorexia)	93	39.5
Dysphagia	92	39.2
Dyspnea	72	30.7
Pain	66	28.1
Sore throat	51	21.7
Neck swelling	20	8.7
Stridor	5	2.1
Regurgitation	1	0.4

As might be expected, hoarseness was the most common symptom—occurring in 81 per cent of patients at the time of their first visit. On the other hand, the frequency with which cough, decrease in general vigor, weight loss, dyspnea and other nonspecific complaints were found, should emphasize to the general practitioner the importance of routine laryngoscopic examination on all patients over forty with these complaints.

TREATMENT BEFORE FIRST EXAMINATION AT THE NEW HAVEN HOSPITAL

The family physician has the all important responsibility of making an early diagnosis of cancer of the larynx, and then, without delay, referring his patient to an otolaryngologist for confirmation and further specific treatment. How well he discharges this responsibility is another matter. Too often, at least in our experience, patients complaining of one or more of the symptoms discussed previously, received prolonged symptomatic therapy after only abortive attempts at diagnosis had been made by their physicians. Frequently, this symptomatic treatment would afford the patient temporary relief "confirming" the initial impression of a "benign" laryngitis or pharyngitis. When the hoarseness, cough or dysphagia would become intractable, indirect laryngoscopy might be done and the patient finally referred for definitive treatment.

In this study, 141 patients or 60 per cent had some type of treatment before their first examination by the E.N.T. staff of New Haven Hospital. Eighty-seven per cent of these patients received symptomatic therapy alone. In all fairness, it should be pointed out that in several of these cases the correct diagnosis was suspected in a matter of days, and patients were referred in with essentially little or no time lost.

NEGATIVE FIRST BIOPSY

Fourteen per cent of the initial laryngeal biopsies in this series were reported as negative for malignancy. One such patient had proven cervical metastases at the time negative laryngeal biopsy was reported. Histological diagnoses included hemangioma, benign polyp, papillomata, hyperkeratosis and chronic inflammation. In the majority of such cases a second biopsy repeated very shortly thereafter revealed malignancy at the same site.

Nevertheless, 31 per cent of those who had negative first biopsies required three or more biopsies before diagnosis was finally made. Patients with suspicious lesions should be kept under close observation so that repeated biopsies can be done if necessary.

TIME BETWEEN ONSET OF SYMPTOMS AND FINAL DIAGNOSIS BY BIOPSY

Of the fifty-two cases that survived five years or more, 40 per cent were treated within six months and a total of 81 per cent, within the first eighteen months, indicating the benefits of early treatment in those patients who have any chance of survival.

MIRROR LARYNGOSCOPY

Mirror examination of the larynx is generally regarded as the first essential step to be taken in ruling cancer of the larynx in or out. The physician's course is clear if the laryngoscopy reveals neoplasm, but what of those cases where no neoplasm is seen on laryngoscopy?

Those first laryngoscopic (usually indirect) unequivocally recorded as negative for cancer num-

bered nineteen in our series, or 8 per cent. Many of these were diagnosed by experienced otolaryngologists as "chronic laryngitis or inflammation." This figure is rather low but serves to emphasize the danger of relying entirely on mirror examination to exclude possible cancer of the larynx in suspected cases.

CONCLUSIONS

1. Cancer of the larynx appears from our figures to be on the increase.

2. Predisposing factors in order of importance seem to be:

a. Infections of the upper and lower respiratory tract and mouth.

b. Industrial exposures.

c. Excessive tobacco.

d. Excessive alcohol.

e. Septal deviation with obstruction.

f. Pulmonary tuberculosis.

3. Although hoarseness is the most common presenting symptom in cancer of the larynx, nonspecific complaints such as cough, decreased general vigor, dysphagia or dyspnea, with or without hoarseness, occur with sufficient frequency in this disease to warrant investigation of the larynx in any patient over forty with these complaints.

4. The importance of early diagnosis and treatment is indicated by the fact that of the five year survivals in this series, 40 per cent were treated within six months and a total of 81 per cent within eighteen months of the onset of symptoms.

5. Indirect (mirror) laryngoscopy should not be relied upon to exclude cancer of the larynx in suspected cases. As Jackson has said, "Death often lurks under an overhanging epiglottis." Direct laryngoscopy will reveal tumors situated in the anterior commissure, ventricle, pyriform sinus, laryngeal surface of the epiglottis and other locations sometimes inaccessible to the mirror.

6. Initial biopsy was negative in 14 per cent of the patients in this series who later were found to have cancer of the larynx. This illustrates the need for a close follow-up by a competent otolaryngologist, of any case of "chronic laryngitis" in a patient over forty.

BIBLIOGRAPHY

1. Jackson, C., and C. L.: Cancer of the larynx: its increasing incidence. Arch. Otolaryng. 33:45-65, January, 1941.

2. Beck, J. C., and Guttmen, M. R.: Neoplasms of the nose, throat and ear; some practical observations upon cancer of the larynx. Ann. Otol., Rhin. & Laryng. 42:607-612, June, 1933.

3. Colledge, L., and Peacock, R.: An analysis of one hundred and twenty-six cases of malignant disease of the upper air passages treated during a period of ten years, 1921-1930. J. Laryng. & Otol. 47:161-187, March, 1932.

4. Moore, I.: Intrinsic cancer of the larynx and the operation of laryngofissure. J. Laryng. & Otol. 33:129-143, 1918.

5. Israel, S.: Cancer of the larynx and its treatment by laryngectomy. South. M. J. 32:911-915, September, 1939.

6. New, G. B., and Waugh, I. M.: Curability of cancer of the larynx. Surg. Gynec. & Obst. 58-841-844, May, 1934.

7. Figi, F. A., and New, G. B.: Cancer of the larynx in the young. Arch. Otolaryng. 9:386-391, April, 1929.

8. Thomson, Sir S. C.: Intrinsic cancer of the larynx; operated on by laryngofissure; immediate and ultimate results. Brit. Med. J. 743-145, May, 1928.

9. Orton, H. B.: Cancer of the larynx; immediate and ultimate results in one hundred and two cases. Arch. Otolaryng. 28:153-192, August, 1938.

10. Jackson, C., and C. L.: Cancer of the larynx. (Text) Saunders, Philadelphia, 1939.

11. Thomson, St. C., and Negus, V. E.: Diseases of the nose and throat (Text), 595-647, Appleton-Century-Crofts, Inc., New York, 1948.

12. Graham, E.: Some questions about bronchogenic carcinoma. N. E. J. M. 245:389-397, September, 1951.

13. Dublin, L. I., and Vane, R. J.: Occupational Hazards and Diagnostic Signs (Bureau of Labor Statistics Bulletin No. 582) 1942 Revision.

14. Frissell, L. F., and Knox, L. C.: Primary carcinoma of the lung, Am. J. Cancer. 30:219, June, 1937.

15. Winternitz, M. C. et al: The pathology of influenza. Yale University Press, New Haven, 1920.

16. Hilding, A.: Experimental surgery of the nose and sinuses I. Changes in the morphology of the epithelium following variations in ventilation. Arch. Otolaryng. 16:9-18, July, 1932.

PRE-EMPLOYMENT MEDICAL EXAMINATIONS TO SELECT — NOT REJECT

Leslie W. Foker, M.D., *Minneapolis*

Much of the effective work in the field of vocational rehabilitation, particularly as it relates to proper placement of workers according to their physical and mental capacities, must be done by the medical service in the industrial plant. The plant physician who has made repeated and thorough observations of the various work operations under his supervision is in an incomparably better position to carry out this function than is any outside agency, for jobs of the same designation vary too widely from plant to plant to permit a wholesale transfer of physical requirements from one plant to another.

It is a common fault to consider as requiring rehabilitation only those individuals with obvious physical defects such as amputations or other deformities of the extremities, severely impaired vision, hernia, and psychoneurotic instabilities. There are many more obscure conditions, equally as limiting in employability—cardiac disease and hypertension, susceptibility to dermatitis, lung conditions which preclude exposure to dust or other air contaminants, diabetes, kidney and liver diseases, arthritis, and back disorders. These conditions can be discovered only by means of careful medical histories and careful physical examinations.

The pre-employment physical examination is the foundation of any industrial health program. It provides not only the basis for the proper placement of workers, but also the fundamental information essential for a sustained health program. Its relationship to an industrial health program as a whole may be shown by a brief outline of the essentials of such a program. This outline contains most of the features of an adequate medical service as advocated by the U. S. Public Health Service, the American College of Surgeons, and the Council of Industrial Health of the American Medical Association. They are:

1. A competent physician who takes a genuine interest in applying the principles of preventive medicine and hygiene to employed groups and who is willing to devote regular hours to such service in the industrial environment, on a full-time or part-time basis, as need dictates.

2. Industrial nurses with proper preparation, acting under a physician's immediate supervision or under standing orders, on full-time or part-time.

3. Preplacement, periodic and re-employment physical examinations. The preplacement examination should be complete, and its purpose should be only to place the worker in the occupation for which he is mentally and physically suited and in which he can work safely and efficiently.

Periodic examinations to detect early signs of occupational and non occupational illness. Frequency of these examinations should be in accordance with the specific requirements of the individual and his exposure.

4. Prompt dependable first aid, emergency, and subsequent medical and surgical care of all industrial disability.

5. Non occupational injuries and illness should be referred to the family physician or proper community health agency.

6. Adequate medical records including physical examination records accessibly filed in the medical department under responsible medical supervision. Statistical summaries and analyses of the injury and illness experienced should be made periodically.

7. Supervision of industrial hygiene service directed at the improvement of working environment and control of all unhealthful exposures, with the assistance of the safety and engineering departments and with the guidance of the state and local bureaus of industrial hygiene.

Address before Institute on Employment of the Physically Handicapped, University of Minnesota, Center for Continuation Study, Minneapolis, Minnesota, September 25, 1948, by Leslie Foker, M.D., Northwest Industrial Clinic, Clinical Instructor in the School of Public Health, University of Minnesota, and Consultant to the Minnesota State Board of Health. Reprinted from the report of proceedings of the Institute, September 1948

8. Supervision and periodic inspection of plant sanitation.

9. Education of the employee in accident and occupational disease prevention and personal hygiene.

10. Program of rehabilitation.

11. Reporting of occupational disease.

It is obvious that most of the preventive aspects of such a program depend upon physical examinations, both preplacement and periodic.

The pre-employment examination is designed, primarily, to place the worker in the occupation for which he is physically and mentally suited, and in which he may work safely and efficiently. Other important purposes which should be mentioned are the following:

1. To detect the presence of remediable defects before they become chronic or disabling.

2. To prevent the spread of communicable diseases by the exclusion of infected persons until their return to work is reported safe by the physician.

3. To eliminate fraudulent claims for personal injury.

The preplacement examination should never be used to arbitrarily weed out persons with physical defects, whether or not they have any bearing upon their capacities to do work. Labor has objected to such practices in the past, and justly so. It is only in recent years that the ill effects of these practices have been overcome. Labor has cooperated and will continue to cooperate with examination programs founded on the purpose of prevention. Experience in large organizations has shown that no more than 2 per cent of all applicants for work have sufficient abnormalities to warrant their being rejected for work.

The following are some of the more common conditions limiting an individual's employability.

1. Heart disease and hypertension. Obviously it is wrong to place these individuals on jobs requiring strenuous exertion.

2. Herniae—these are one of the most common causes for rejection for employment. In most cases this is not justified since experience has shown that a man with a hernia which is reducible and which can be held in place by a well fitted truss, can do the heaviest type of work without difficulty.

3. Varicose veins—these are also a common cause for rejection yet if they are supported by an elastic stocking or elastic bandages they rarely break down into an ulcer. The important thing in the case of varicose veins and herniae is to discover them and support them.

4. Diabetes. The routine examination of the urine for sugar should be done in every general physical examination. Even the presence of small traces of sugar in the urine should be carefully followed up. The presence of diabetes is rarely an indication for the refusal to hire an individual since diabetes can be so effectively controlled by modern methods.

5. Tuberculosis. Cases of active or infectious tuberculosis of course are not employable and must be reported to the health authorities. Persons with inactive tuberculosis should not be placed on jobs in which are present dusts or fumes which may reactivate their lesions, or on jobs which are unusually heavy or in which they are exposed to extreme temperature changes. They should be reexamined at frequent intervals, such as every 3 to 6 months, for signs of reactivation.

6. Syphilis. The serological test for syphilis should be part of every routine industrial physical examination. No worker should be rejected for employment or removed from employment because of the presence of a positive serological test, unless he has syphilis in a communicable state, or he has sufficient involvement of the heart or central nervous system to be a hazard to himself or to his fellow workers. With these exceptions he should be hired or retained on the job provided he obtains adequate treatment from his private physician. He should be required to submit periodic reports from the treating physician, at 2 or 3 month intervals, to the plant medical director to the effect that he is continuing to receive such treatment. The confidential nature of reports of positive serological tests must be carefully guarded and should be kept in the files of the medical department.

The periodic physical examination, which is equally as important as the pre-employment examination, should be briefly mentioned here. Its purpose is to detect early signs of occupational and non occupational illness and to conserve the health of employees by the early detection of illness and degenerative diseases attendant upon the ordinary processes of wear and tear and aging. In certain industries in which special hazardous processes exist, special types of examinations are done at intervals determined by the severity of exposure. For ex-

ample, in the lead industry or in the benzol industry, frequent examinations of the blood are performed to detect early signs of intoxication from these materials. In many plants, it has been the policy to examine all the workers at intervals of two or three years, often with the exception that older workers, particularly those in more hazardous occupations, are examined at yearly intervals.

In instituting the plans for periodic examinations in industry, there are a number of important considerations to be borne in mind. These have been outlined very concisely by the Metropolitan Life Insurance Company as follows:

"1. Examinations should be done with the cooperation, approval and good will of the workers. A publicity campaign may help to enlist the interest of the employees by teaching how great a benefit such examinations are to the workers themselves.

"2. It is judicious, if the examination is an entirely new departure, to begin the program for physical examinations with the institution of employment physical examinations for new employees—offering 'health examinations' to employees as a voluntary measure. The older personnel has an important influence in the plant, and it is desirable that they should heartily believe in the idea before any compulsion is brought to bear.

"3. The examination should always be planned in such a way that an opportunity is given for personal conversation of the applicant with a doctor or nurse in order that the object of the proceeding may be carefully explained in each case. Equally, the findings of the examination should be tactfully and patiently interpreted to the examined without unduly alarming him, of course, before he leaves the medical department.

"4. The confidential relationship between patient and doctor should be kept, and all records of physical examinations should be filed in the medical department and be solely under the control of the medical personnel. Many misunderstandings may be averted if this rule is scrupulously regarded and constantly impressed upon the workers.

"5. A good method for establishing in the minds of the workers conviction of the sincerity of the management's motive as well as thorough confidence in the medical personnel, is to begin with the examination of the executives. Unless the service is good enough to command the respect of the executives, it is not good enough for the employees. Moreover, this is sound procedure from many angles since officials, managers, and laymen in the company benefit just as surely from the examination as any of the workers. A breakdown in health among the higher paid personnel upon whom great responsibility rests is a more costly and more disastrous occurrence than physical disability of many of the less highly trained workers."

The next problem, assuming that a proper physical examination has been performed, is that of developing techniques in handling and using records of physical findings in effecting proper placement. Curent practices vary widely. A common procedure is that in which the examining physician submits the physical examination record to the personnel or employment office, where a lay person interprets the findings to the best of his ability. This is not regarded as ethical, since physical examination records are confidential information and should be kept in the medical department under responsible medical supervision. In some cases, personnel or employment officers, through growing up within the industry, have developed a fair degree of acuity in interpreting medical records, but the method of hit-or-miss, and the company is likely to find itself in an even more precarious position if the services of that individual should be lost.

According to another method, the plant prepares lists of jobs suitable for each disability group, such as one armed, one legged, or one eyed workers. This has one advantage: it stresses the point that every job does not require an able bodied worker. The disadvantages are numerous. Chiefly, the assumption is that all individuals with a specific disability are incapacitated to the same degree. Work opportunities tend to be too much limited, since workers are identified with a specific list of jobs.

Another common approach is through the use of various rating scales. The examining physician using this method employs symbols or terms to indicate the degree of physical competency. For example, he will send the employment officer a statement that the worker examined is suited for arduous, moderate, or light work in a certain department. He may use an A, B, C, D scale—A indicating that the applicant is physically fitted for any work, B that he has a negligible or correctible defect, but is otherwise fitted for any work, C that his defect limits fitness for work, and may or may not need medical attention, and D that his defects require medical attention and disqualifies for employment. Besides

providing only very limited subjective information, this system has the disadvantage that it is impossible to make reliable definitions for these terms which will allow for the inherent elements of time and intensity in physical activities.

At the present time efforts are being made to develop techniques involving a formal pattern for the selective placement of workers in accordance with their physical capacities. Typical of this system is the recent "Physical Demands and Capacities Analysis" developed by the War Manpower Commission. The essential feature of this system is the analysis of the physical demands of the jobs and the physical capacities of workers along the same basic pattern. It was found that both the physical demands of the job and the physical capacities of a worker can be classified under 25 major headings, such as lifting, carrying, handling, standing, hearing, and color vision. It was also found that both the environmental demands of the job and the environmental capacities of the worker can be analyzed under 25 major headings, such as inside work, outside work, high temperatures, low temperatures, night work, noise, etc. A prospective worker's capacities in regard to these various factors are checked by the examining physician on a form, and this form is then compared with one showing the demands of the occupations for which the individual may qualify according to skill or experience. Notations relative to the duration of time certain activities may be carried on are also made on the physical capacities form. This system provides a fairly simple and exact method of matching physical capacities and demands; it eliminates any necessity for the interpretation of physical findings by a lay person; no diagnosis is required and medical records are kept within the medical department; and nothing in the system singles out the handicap, the individual being rated on his abilities. This plan is being studied and modified by many interested groups. It appears to be the most promising approach to job placement according to physical capacities.

A common weakness in most efforts at selective job placement is that the handicapped worker may be transferred from his original position to another without knowledge of the medical department. One company has evolved a system to obviate this. A medical sticker is attached to the employment record of each physically handicapped person. Whenever an employee is to be transferred, a transfer slip must be sent to the employment office and must be added to the individual's file. A medical sticker on the individual's file indicates that the transfer must clear through the medical department. Obviously, with a system like that developed in the Kaiser Shipyards, it would only be necessary to match the individual's capacities analysis with the demands analysis for the new job.

In summary, that phase of occupational rehabilitation which relates to the proper placement of workers according to physical capacities may best be accomplished by the following program:

(1) Proper evaluation of the physical requirements of the position. This can best be done either through thorough and repeated observations by the physician supervising the plant medical program, or by some formal system of physical demands and analysis such as that developed by the Kaiser industry.

(2) Thorough physical examinations to evaluate physical capacities.

(3) Re-examination of employees at intervals to determine continued fitness.

(4) Maintenance of complete records within the files of the medical department.

(5) Adequate techniques for the interpretation and reporting of physical capacities to the employment officer.

(6) An adequate system of follow-up to insure that corrective procedures indicated in the course of the examination are carried out.

TWENTY-FIVE YEARS OF SURGERY IN A SMALL HOSPITAL

KARL T. PHILLIPS, M.D., *Putnam*

AS THE years fly by it is good to stop occasionally and look back, to see how far we have come. The title of this report is not limited to operating technique but includes staff organization, hospital government, personnel problems, the general practice of medicine, educational projects and, last but not least, statistics.

Reading the record of a staff meeting of the Day-Kimball Hospital just twenty-five years ago, one finds interesting milestones in the progress of medicine. "Three inches of greatly thickened ileum found at the time of an appendectomy." Regional ileitis had not been described. Tannic acid was reported as "very satisfactory" in the treatment of second degree burns. After a full discussion of the treatment of pneumonia, one physician said that in his opinion the treatment consisted of morphine and digitalis.

A member was asked to report at the next meeting what he considered the twenty most important drugs. The entire list is not recorded but after a vote has been taken thirteen drugs received unanimous approval. They were: ether, mercury, biologicals, morphine, magnesium sulphate, atropine, digitalis, iodides, salicylates, soda bicarbonate, silver salts, bromides and ammonium chloride.

One physician brought back a report from the Connecticut Clinical Congress that transfusions were valuable for "many and varied" conditions.

The progress made during the past twenty-five years in all hospitals is an exciting chapter in medical history. At the Day-Kimball Hospital, the improvement in the care of the patient, the enlargement of buildings, the increased facilities and better educational program are probably not outstanding. They are, however, what we are interested in at the moment. It has been a natural growth. My reason for reporting them is that I believe that from such an analysis one can learn what improves the care of the patient and what does not.

Let us go back to 1927 and see what was going on a quarter of a century ago. I could go back six years farther but round numbers are always more interesting.

Staff meetings started in 1923 but were social gatherings and were held in physicians' homes. Regular monthly meetings at the hospital started in 1924 and permanent records were kept. They are bound and are the source of much of the material in this report.

The surgical staff in 1927 consisted of the senior surgeon, Dr. Seldom Burden Overlock, and two juniors. The hospital had about 75 beds. During this year 140 major operations were performed and there were 13 postoperative deaths, a 9.3 per cent mortality. There were:

71 appendectomies with 2 deaths
12 cholecystectomies and 4 cholecystostomies with 3 deaths
1 choledochostomy and 1 death
16 herniorrhaphies
2 herniorrhaphies for strangulation with 2 deaths
10 mastoidectomies
3 removal of tubes and/or ovaries
3 hysterectomies
3 perineorrhaphies
3 gastrostomies
2 open reduction for femoral fractures with 1 death
2 cesareans (classical)
2 enterostomies
1 cranial decompression and 1 death
1 suturing of a perforated peptic ulcer and 1 death
1 gastro-enterostomy and 1 death
1 prostatectomy
3 miscellaneous abdominal procedures with 1 death

During the years a great change has taken place in the theory of abdominal drainage. Antibiotic drugs of course have had their influence too. Drainage by means of tubular, cigarette and tissue drains were common practice in 1927. A case of perforated appendicitis would have two or more drains. A perforated duodenal ulcer case would have a drain in the incision and one through a stab wound "draining" the pelvis. Postoperative adhesions were fre-

Presented at the Windham County Medical Association, Willimantic, April 17, 1952

quent and many operations were performed for intestinal obstruction. These usually included an enterostomy. Mastoidectomies were common procedures. These were all done by the general surgeon as were the prostatectomies and classical cesareans. An oft repeated saying was "If you don't like blood, don't do cesareans."

The operating team consisted of the senior and junior surgeons, the anesthetist and the scrub nurse. The superintendent of the hospital, who was a registered nurse, was our scrub nurse. Murphy buttons were used to repair intestinal injuries. Redundancy of the cecum was plicated. Transfusions were used rarely because the danger of a fatal reaction was always before us. Parenteral fluids were usually given subpectorally. Urinalysis and blood counts were done by the anesthetist. Tissues were examined at the Brady Laboratory, eighty miles away, when gross examination was inadequate.

Prior to 1926 x-ray films were taken by a local electrician, who developed them in flat pans. One can imagine that he was not always available. Our interpretation of gastrointestinal series was often misleading. Since 1926 we have had a roentgenologist who came to the hospital at first once a week and now three times a week.

The operating room was on the top floor of a wooden wing. Instruments were boiled six feet from the operating table. We wore gloves soaked in bichloride solution. Talcum powder granulomata were unknown.

In 1928, 180 major operations were performed and the mortality was 7 per cent. Radical surgery was done for some cases of carcinoma of the stomach and colon but the results were discouraging. Many died of postoperative shock. In open wounds erysipelas was greatly feared. In 1929 the operative mortality was 10 per cent and in 1930, 4.4 per cent.

The American College of Surgeons made their first inspection of the Day-Kimball Hospital in 1929. Many recommendations were made and some seemed impossible to carry out at the time. However, three years later we were approved conditionally.

Mortality studies of certain operative procedures were made from time to time. Fifty-four operations on the gall bladder were performed between 1929 and 1934 with an operative mortality of 11 per cent.

At the death of Dr. Overlock in 1934, the three senior surgeons served on the surgical ward service three months each. We assisted each other and as properly trained young men arrived they were appointed as junior surgeons.

A business man replaced our nurse superintendent in 1937. The daily average of patients at this time was around 64.

Postgraduate study took the place of vacations for some of us. Dr. Paul D. White of Boston taught the mysteries of the human heart and electrocardiography to one of our physicians and she has been our cardiologist ever since.

Better tissue examination service, including frozen sections, was badly needed and in 1940 arrangements were made with the Hartford Hospital to supply us with a pathologist. At first we were able to have frozen sections only once a month but at present they are available once a week.

A hospital without residents or interns is apt to have trouble in the Record Room. It has been said that a hospital without accurate records is like a clock without hands, running but nobody knows what time it is. Various methods were used to get better charts and unfinished charts completed. Names were posted weekly but to this, immunity soon developed. A monthly report of the Executive Committee of the staff in 1941 has this paragraph about the Record Room which quite adequately tells the story. "This department is still enjoying and also adhering to its past tradition of being a disgrace to our hospital, to the staff and to the medical profession."

Ten years of rising costs in hospital financing have made changes that we do not realize until we see the actual figures. In 1941 an increase in rates was announced. Service Ward rates that had been $14 were raised to $17.50 a week. This was only eleven years ago.

A new wing was added in 1941 which, besides other increased facilities, created a new surgical suite with two major operating rooms. During this year a new Record Committee was appointed. A Journal Club was organized and monthly meetings held at members' homes. A library fund was procured from our members and this paid for new books for the hospital library and a generous number of journals. This project was started by one of the younger staff members and has been guided by him since.

In 1943 a Tumor Clinic was started at the instigation of Dr. Mathew Griswold of the State Depart-

ment of Health. One of the younger members of the staff was appointed as chairman and he has continued in this position. At first it met once a month and at present three times. The clinic has always included private as well as service patients. In fact, private patients outnumber the latter.

Monthly staff meetings were originally held in the evening after office hours and rarely started before 9:30. Poor attendance and late hours were our problems. A new plan was tried that has worked well. The members were asked to give up office hours one evening a month. We now meet at 6:30 P. M., have dinner and the business and clinical meeting follow. All deaths are reported in detail as are the unimproved cases. Each member present is asked to report any interesting patients or meetings that he has attended. Autopsy findings are reported.

There were few post mortems twenty-five years ago. We have to do them ourselves. In 1951 there were 95 hospital deaths and 45 autopsies, a little over 47 per cent. We hope to improve on this but when one realizes that there are no interns to help, I believe this is a fairly good percentage.

A study of cesarean sections seemed to be of particular interest since the low cervical operation had been employed. Such a study was made in 1946. One hundred and three sections were done from 1932 to 1946. During these fifteen years the incidence of cesarean sections to live births was 3.2 per cent. Since then, listed separately, they are as follows: 1947, 4.2 per cent; 1948, 5.7 per cent; 1949, 5.7 per cent; 1950, 5.1 per cent; 1951, 4.4 per cent. Since 1932 there have been 275 cesareans with no maternal mortality.

Five years ago we realized the need of group discussion of problems in diagnosis and treatment. Weekly grand rounds were started. The same member of the staff has served as chairman ever since. The cases are usually hospital patients but outside patients are often examined. The attendance is good and I believe the patients derive great benefit from these conferences.

For many years the junior surgeon on ward service was on call for the accidents that were brought to the outpatient department. This dual job became more than could be handled properly. In 1947 accident call was placed on a weekly basis and five members of the staff, four of them surgeons, rotated on call. In any hospital the treatment of accident cases is an extremely important public relation problem.

During this same year the Record Committee, although it had continued to exist, was "born again" when the Trustees ruled that physicians with unfinished charts, more than a month old, could not admit new patients. This committee was authorized to enforce this new rule.

In 1947 a fourth junior surgeon was appointed increasing the surgical staff to six.

In 1948 the Trustees undertook to raise $600,000 to build a new double wing increasing the basic facilities and increasing our beds. The staff had never had a good place in which to meet. The monthly staff meetings had been held at the Nurses' Home and our grand rounds, clinical pathological conferences and tumor clinics had been held in the laboratory. While we were there the laboratory could not function. In the campaign for funds twenty-five members of the staff pledged $41,000 for a clinical meeting room. With $300,000 of Federal funds from the Hill-Burton Act and $600,000 raised from the community the new building was completed this spring. We now have 110 beds, new operating rooms and an entirely new x-ray department. The operating suite that was built in 1942 was made into an obstetrical department. The new wings also include a kitchen, cafeteria, dining rooms, boiler room, laundry, outpatient department, clinical meeting room and a postmortem room. A coffee shop and gift shop have been created by the Woman's Board.

In 1951 an anesthetist was added to our staff who devotes his entire time to anesthesia. During the period of building and change over admissions have been curtailed and less surgery was done than during recent years. In 1951, 495 major operations were performed. There were six postoperative deaths, an operative mortality of 1.2 per cent. There were:

97 appendectomies with 1 death
57 cholecystectomies; in 17 the common duct was explored, an incidence of a little less than 30 per cent
31 complete hysterectomies
32 cesarean sections
18 exploratory laparotomies with 1 death
20 colporrhaphies of all types
10 vaginal hysterectomies
7 radical mastectomies
2 simple mastectomies
6 femoral vein ligations
15 thyroidectomies and excision of thyroid adenomata
6 prostatectomies with 2 deaths
17 resections of colon or rectum for carcinoma
4 subtotal gastrectomies

4 gastro-enterostomies
99 herniorrhaphies of all kinds
2 biliary anastamoses to the gastro-intestinal tract, for carcinoma of the pancreas, with 2 deaths

What can we learn from this quarter of a century of work that will help the patient? I believe that these conclusions can be drawn.

Fair dealing and cooperation should be exercised with the young physicians as they come along. Responsible jobs should be given to them. Allow them to head up the tumor clinic, grand rounds, library committee, journal club, photographic departments, etc.

Encourage consultations among the staff. The American College of Surgeons has been urging consultations for years. They should not be casual. What the consultant believes to be true, he should be willing to record on the chart. We believe in all this and more. We believe that all consultations should be free and we have followed this plan for many years. The only exceptions are the oculist, otolaryngologist and cardiologist. If we had a pediatrician he would of course, be excepted. We think that this is good practice and results in better care of the patient.

The scheduling of all operations is done by the supervisor of surgery as to time and she makes all arrangements for assistants. She seems to be able to do this better than anyone else because she knows who is operating and who is free. This may seem a minor matter but if it makes things run smoothly, it is not minor.

Postmortem examinations are very desirable. There is one rule that will succeed in getting a high percentage. It is: never fail to ask for them.

The improvement in the care of the patient during the past twenty-five years has been, of course, due to many things but I believe that the stimulation provided by the American College of Surgeons has had no small part in this progress.

HEALTH OF THE WORLD'S CHILDREN
(Childhood in the Old World and the New)

MARTHA M. ELIOT, M.D., *Washington, D. C.*

The Author. *Chief, U. S. Children's Bureau*

IT IS a very real pleasure and satisfaction to me to be here today with you and to be able to bring you some facts about children in the world around us including our own. I think too that it is important to consider (1) the responsibilities for leadership that lie heavily upon us in this country because of our economic prosperity and educational advantages, and (2) how we should fulfill these responsibilities. As we join people from other countries and go forth into the world carrying with us the tangible evidences of our good will toward other peoples, it becomes ever clearer that our emissaries of this good will and our bearers of gifts and know how should have certain knowledge and qualities of personality that are essential to the establishment of friendly relations. These qualities we know well here at home. They are, in the main, the same as those that all of us must have if we are to accomplish our own objectives in public health or in any one of the social services. They are the characteristics that make for good interpersonal relationships, for ability to work within the group and for ability to work team with team—characteristics that help us recognize the skills, the capacities, the strengths, the superiority of ideas, and the basic cultural differences and assets of the other fellow.

My two years work with the World Health

Presented at the 18th New England Health Institute, University of Connecticut, at Storrs, June 19, 1952

Organization enhanced to a great degree my realization of the potential strength that lies in the international program of health, and the chance it gives to the participants in these programs to spread a better understanding of the true meaning of human rights, of individual opportunity, integrity and security; and of the effectiveness of group action and the responsibility of the individual to the group. And I have learned too, how inadequate is our knowledge and understanding in this country of the history and meaning of the many different cultures in the world and the contributions these cultures make to the total well being of all nations.

Today through the World Health Organization some 80 nations are joined together to work on the common problems of the health of their people. These problems, I believe, will only be solved when the cultural differences and the cultural advantages of the various nations are so well understood that despite differences, and to a great extent in accord with them, new knowledge for the preservation and restoration of health can be assimilated and utilized effectively by each nation as it becomes available. This may sound irrational to you. You may think I am overlooking the economic barriers that exist. Of course, I am aware of the vast economic problems that exist in bringing health to families, to villages, and to towns, and to the great metropolitan areas in countries that are less well developed from an economic viewpoint. The cost of environmental sanitation projects alone, which are so fundamental in so many parts of the world, raises barriers that seem almost insurmountable; barriers that are so overwhelming that one wonders how many decades it will take before we can overcome them. What I am really trying to say is that given the economic resources and the know how, success can be achieved only as we adapt the knowledge we have so that it can be put into practice in the many different cultural settings of the different nations. As this happens, the international health program will weave a network of common understanding with fibres so strong in the aggregate that hopefully they will indeed help bind the nations together for peace.

This is the job the World Health Organization has tackled, and in so doing, certain lines of effort have been gradually established. Four and five years ago members of the organization thought only in terms of certain outstanding needs; needs that were and still are overwhelming in a majority of underdeveloped countries. These included malaria, tuberculosis and venereal disease control, maternal and child health services, nutrition and environmental sanitation. At the start the first four got most attention and most of the available money. It was inevitable that the earliest requests were for demonstration teams to set up malaria control projects, or tuberculosis control clinics, or venereal disease treatment centers. The possibility of joint projects with the United Nations International Children's Emergency Fund at once gave prominence to programs centering on children.

Today, however, there is quite a different outlook. The necessity to strengthen the national and local administrative processes and to put more emphasis on environmental sanitation is coming to the forefront of action. April 7 is now celebrated in many countries as World Health Day, and the theme that was emphasized this year was "Healthy Surroundings Make Healthy People." Obviously, activity in the priority subjects cannot be lessened if the impact of the health program is to be felt soon by the people of underdeveloped countries, but emphasis now on more adequate public health administration and on environmental sanitation will lay the foundation for a more rapid extension of the programs for communicable disease control and for maternal and child health service. This is as it should be.

I hope you will forgive me for this early digression away from the subject in hand, the health of the world's children. Actually, the development of the overall program of the World Health Organization, geared as it is to the concepts that "health is a state of complete physical, mental and social well being" and that the "health of all peoples is fundamental to the attainment of peace and security," is basic to the health, welfare, and educational activities in behalf of the world's children. Indeed, it has real meaning for us here at home.

Let us look for a moment now at a few facts and figures.

Today, somewhere in the world, 200,000 babies will be born. Only about 11,000 of these will be born in the United States.

Somewhere in the world today, some 900 million children under 18 years of age are living. Only 48 million of these are in the United States.

Of the 900 million children in the world about 300 million are white, about 600 million are colored.

In the United States the proportions are reversed sharply—about 42 million children are white, about 6 million are colored.

Of at least 70 million babies born in the world last year, probably about 15 per cent, 150 per thousand, or more will have died before the end of their first year of life, in some countries as high as 25-30 per cent or even higher. In the United States only about three per cent will have died.

In many countries of the world babies born alive have scarcely a 50-50 chance of reaching maturity. These are the countries that are least well developed from an economic point of view, less urbanized, less industrialized, where the family is the important unit. They are largely situated in tropical or semi-tropical parts of the world. Most of the people live in villages and in rural areas where there is little sanitation as we know it, where there is little or no medical care, where families must depend on each other for whatever welfare service there is, where schools are primitive.

In these less well developed countries enormous numbers, literally hundreds of millions of people including a vast majority of the children, have serious tropical diseases such as malaria, schistosomiasis or other intestinal parasites, trachoma, yaws, leprosy. Millions have tuberculosis. Malnutrition is almost the rule. Many millions of people, including children, die each year of these diseases, or are weakened to the point that they cannot do a full day's work, or they must quit work very often. Earnings are low. The general economic situation is bad. Because of all this, food production suffers seriously, housing is very inadequate. Schools are scarce, and the standards of living for hundreds of millions of the poorer people are depressed far below the standards that the customs and culture of their own countries provide for people of higher economic level. Under these conditions a heavy toll is taken in lives and in health and in the well being of children. Because schools are scarce, only a small proportion have the advantage of education.

In the temperate climate of Europe, most of North America, and in the temperate parts of Australia and in New Zealand, we find, of course, a totally different picture. In these areas children live under vastly different conditions, and death rates are strikingly lower. By and large, the economic conditions are better; urbanization and industrialization are more the rule; employment is more continuous; housing and schooling are better, though still far from perfect; communicable diseases are greatly controlled; and generally some kinds of health and welfare services are available to families though they vary greatly in extent and in quality. According to western cultural standards, opportunities for life and health and education for children and young people are much more prevalent than for children in the hotter climates and less well developed countries.

In Latin America the situation seems to fall in between. In some countries urbanization and industrialization has been proceeding and is absorbing many people from rural areas; but in most, agriculture and rural life predominate and the economic situation is poor for the rural people.

Here in the United States where family incomes are relatively high, where industrialization is far advanced, where agricultural development has been rapid, where 60 per cent of all the people live in cities, it is true that to a very considerable extent our children have certain kinds of advantages that we have learned to prize highly—life in a free community, education, good housing, recreation facilities, play space, health and welfare services, medical and hospital care when sick; vocational counselling, community activities that make for good human relations, and above all, warm and congenial family life. These are what we like to think of as conditions in which the average citizens of the United States can live and bring up their children, and indeed it is true for vast numbers of our families.

But, as we here know well, the picture is not as rosy as this for hundred of thousands of our children. For many, life is dark and unhappy. The advantages that I have enumerated do not reach nearly all our children either in cities or in rural areas. For too many children schools are poor or lacking; housing is wretched; health and medical services are inadequately available or inaccessible; opportunities for recreation or play are few or non existent; employment is unsuitable or is forced upon children too early; homes are broken; some children are footloose and on the streets; many are picked up by the police, held in jails, and come before the juvenile courts.

Of all our children, certainly some of the most disadvantaged are those who belong in families of migrant workers, those who live in isolated communities such as mining and mountain towns, and many who are members of minority groups in both urban and rural areas. The conditions under which

many of these children live are a blight on our national life.

Then, too, in an ever increasing number of homes today, the mother as well as the father has a job and is away from home for long hours, leaving the children to shift for themselves or to stay with neighbors. Suitable day care facilities are too few or do not exist at all for many of these children. There are well over 7 million such children of employed mothers in the United States today. With the increased employment of mothers in connection with defense and mobilization, no doubt this figure will mount even higher.

Today in the United States there are one and one half million dependent children in families aided by public assistance under the Aid to Dependent Children's provisions of the Social Security Act, and another 7 or 8 hundred thousand in families receiving benefits under the provisions of the Old Age and Survivors Insurance program. Too many of these families are receiving insufficient amounts to provide for a decent standard of living. These children have one great advantage, however: they are at home with a parent or relative and though their home life may be disturbed, though some may even be neglected, at least the children have the security and the sense of belonging that comes because someone close to them is in the home to hold the family together. Though the Aid to Dependent Children program comes in for a good many brick bats today, we cannot get away from, nor do we want to forget, the immeasurable good that this program accomplishes when it assures life in their own homes for these million and a half children. But homes broken by divorce or separation of parents, though economically secure, often make for emotional insecurity and maladjustment in the children.

To round out the picture, may I remind you that about 104,000 children are in institutions for dependent children, 175,000 children are away from their own homes for temporary or permanent placement in foster family homes supervised by child welfare agencies, approximately 350,000 delinquent children come before the juvenile courts each year, somewhere between 50 and 100 thousand delinquents are detained in city and county jails while awaiting court action, 30,000 boys and girls are in training or correctional schools for delinquent children. In 1951, 80,000 adoptions were recorded; of the children adopted by non-related persons only about one half were handled by recognized child placing agencies. This means the other half were independent placements through parents, relatives or friends, or, in some instances were children placed through the so-called "black market for babies" where arrangements for adoption are made by unscrupulous people who find homes for illegitimate babies for a price, often a very high price.

In addition to these social disadvantages, countless children are not getting the full benefits of preventive health services or medical care that we know how to give. Many handicapped children go without the benefits of modern medical and psychological knowledge.

All this is, of course, familiar enough to you. From it we reach an easy conclusion that though we in this country are economically better off than people in most other countries, we cannot be complacent with respect to what our own children face today. Moreover, when we add to all this the emotional strain and stress brought to bear on the people of this country (1) by the lack of security and stability resulting from defense and mobilization activities, (2) by the fluctuations in employment in some defense industries, (3) by the number of young families that are broken up through the enrollment of the father in the armed forces, (4) by the increase in juvenile delinquency that has accompanied the stress of this period, (5) by the small number of adequate day care facilities and nursery schools that exist to meet the needs of children in defense areas, we become vividly aware of what current life in this country must mean to children, especially in terms of their emotional development.

But the picture the world over is not by any means wholly dark for children. There are indeed many bright rays of hope. Real progress can be made in many countries if international programs that have been initiated can expand and grow.

The work of the specialized agencies affiliated with the United Nations, together with that of the Social Activities Division of the United Nations itself, and with the United Nations International Children's Emergency Fund (UNICEF), can bring much to all the world's children in terms of new knowledge, professional and technical skills and, indeed, material help. Today the World Health Organization and UNICEF have joint health projects for children and mothers in a great number of countries in Southeast Asia, the Western Pacific, the Eastern Mediterranean, European, and the Latin

American regions. Hundreds of thousands of children are being reached in one way or another. Health departments in countries that are members of these organizations or of the United Nations are receiving help with their own services if they wish it. In the same way, the Social Activities Department of United Nations is reaching out with the help of skilled social workers to these countries, and children are benefitting. The International Labour Organization and the Food and Agricultural Organization are increasingly active in behalf of children, the former with respect to employment, the latter particularly with respect to nutrition and food production. About a year ago a coordinating committee of the United Nations, the specialized agencies, and UNICEF was set up to facilitate joint planning for children.

The knowledge and skills that we have today to assure good physical growth and health in children are very extensive thanks to research and to opportunities to test our knowledge that have been presented during the past half century. The effect on child life is reflected in many countries, especially in Europe and North America, in the dramatic decrease in the infant and maternal mortality rates, in the reduction of certain communicable diseases, and in the general improvement in child nutrition and in environmental sanitation, malaria control, BCG campaigns against tuberculosis, and yaws eradication. Current research in the control of communicable diseases will, we hope, do away, in due course, with such scourges as rheumatic fever and poliomyelitis, and hopefully research will help us with preventing congenital malformations and other physical disorders. Where knowledge can be put to work, fewer and fewer children should die before reaching maturity. Our immediate and long-range task, as far as physical health is concerned, is to make our knowledge and skills increasingly effective in the lives of all the world's children; to find new and appropriate methods of work and to organize health, welfare, and educational services in such ways that no child will go without both preventive and curative medical care. This is indeed true here in the United States as well as elsewhere—even though the total degree of need may be less.

But to assure children adequate medical care is not enough. The social and emotional development of each child must now have high priority in our planning as we consider how the needs of children in the world today must be met. It is of prime importance here in the United States where tensions are high and where urbanization and industrialization deprive so many children of normal family life and simple community social activities. We cannot allow ourselves to forget that under our present day way of life we may anticipate that approximately one out of every 20 new born children will sooner or later find themselves in hospitals or institutions for the mentally sick.

But thanks to an increasing body of knowledge brought to us by psychologists, psychiatrists, anthropologists, and other social scientists, we are now much better prepared than we were two decades ago to give advice and help to parents and to all people who work with children on how to guide the emotional development of children. The Midcentury White House Conference brought together much information resulting from study and experience that will serve to set guide lines for action in the care and rearing of children. The insights into the emotional development of the child outlined so effectively in the report of the Fact Finding Committee,[1] must influence profoundly our health and social policies and procedures in working with parents in their own homes, and in planning for the care of children when removal from their own homes is necessary. Policies with respect to adoption practices, practices employed in foster care, practices in pediatric and obstetric departments of hospitals, in convalescent homes, in health centers and clinics, and in doctors' offices must stem from our new knowledge of the stages of emotional development in the infant and young child. Advice that will be given to an unmarried mother, to prospective adoptive parents, to foster parents, to workers in children's institutions of all types, or in day care centers must be geared more and more to the current knowledge of the need of the baby and young child for a warm, close mother-child relationship. The meaning of the adverse effects of deprivation of maternal care, if separation from the mother takes place after the earliest months of infancy and during the first three or four years of life, must be understood by health workers as well as social workers.

The urgency of recognizing "the cardinal significance of maternal care for the preservation of mental health" has been brought out most forthrightly by Dr. John Bowlby, a psychiatrist from the Tavistock Clinic in London, in his recent report on Maternal Care and Mental Health[2] prepared for the World

Health Organization. Let me recommend this report to you, if you have not already seen it, for it has within it information and pertinent advice that will be of interest to all who work with children. It brings together current knowledge resulting from studies and research that will change practices in the child welfare and child health fields fundamentally. It even discusses the administrative aspects of the practices current in various countries.

I am not unaware of the fact that already changes are taking place in more advanced and well informed social agencies and in some clinics and hospitals and health services, but a great deal of work still lies ahead before we will be able to assure ourselves that the principles of dynamic psychology are incorporated in all of our work with children. Much more research to bring out still more facts, and better training of health and welfare workers in appropriate methods are most urgently needed. Resources to enable competent investigators to undertake research, to evaluate current practices, and to permit schools of medicine, public health, social work, and nursing to expand their curricula are still very inadequate.

But today the hopeful thing for children, and for the world, is that the facts about the emotional development of children are already being unfolded and in such a way that our practices can be modified. Just as it took long years—decades—to learn the facts about physical care of children and to put them into effect, so it will take time to move effectively in this field of emotional development. Even though the way appears difficult and the barriers of tradition hard to surmount, somehow we have to find our course. If we move on a wide front in our total approach to child health and welfare, if we give the facts to the public, and in particular to parents, as fast as they are shown to have validity, the effect will be cumulative.

And may I remind you again that in this year, 1952, some four million babies will be born in the United States. This means four million opportunities to start these future citizens on the road to physical, social, and emotional well being. Public health workers, especially the public health nurses, practicing physicians, and doctors and nurses and social workers in clinics and hospitals have a peculiar responsibility here, because it is they who have contact with the young mother when she is first pregnant and with the father early. Our obligation to do what we can to start these four million children down the right road is very great indeed. Upon what we do now, and in the future, to help parents in their task of raising a whole generation of trustful, secure, competent, independent, well integrated children and youth will depend in the last analysis the future peace and security of our country, perhaps even the future peace and security of the world. Our obligation today is greater perhaps than that of any other country for we have a great leadership role to play in international affairs. To play this role well, we must have one generation after another of young people able to take their places effectively in national and world society and to assist in group decisions that will make for peace. Without individual emotional stability and health, without the ability to work in a group and to carry their share of responsibility for the group, these future citizens will fail, as we have so far, in establishing peace in the world. To raise these generations of emotionally secure young people is no easy task, but it must, indeed, be regarded as objective number one. Indeed, everything we do, in the last analysis, must be planned in the light of this objective.

BIBLIOGRAPHY

1. Witmer, Helen L., and Kotinsky, Ruth, editors: Personality in the Making: The Fact-Finding Report of the White House Conference on Children and Youth. New York: Harper & Brothers, 1952. 454 pp.

2. Bowlby, J.: Maternal Care and Mental Health: A Report Prepared on Behalf of the World Health Organization as a Contribution to the United Nation's Programme for the Welfare of Homeless Children. Geneva: World Health Organization, 1951. 179 pp.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Windham: Brae Rafferty, *Willimantic*

EDITORIALS

Specialism and the Intern Year

The growth of specialism is the direct result of the great developments in technological medicine. It has however, potential dangers, one of which is if it is carried far enough it will lead to depletion if not the disappearance of the general physician. Of all doctors, the latter is of first importance for medicine, not only for the important and unparalleled service which he renders but because it is his broad outlook which must continue to be carried over into the training of medical students to preserve the art of medicine.

It is well known that practically all medical school teachers are specialists in their various fields. Regardless of whatever broad outlook these men may have, the emphasis which obviously must be placed on the special subject tends to have a narrowing influence on the mind of the student.

A like influence is found in specialism itself and the prestige values for the doctor in board qualification. Even in early undergraduate years the medical student often begins to plan a specialized postgraduate course to begin immediately after graduation in specialized intern training.

It is because of this demand that teaching and other hospitals offering such internships find but little difficulty in filling house-staff positions. Many hospitals offering good general internships have difficulty in filling their quota.

One remedy which has been suggested is that the specialty board reexamine the worth and soundness of intern training in general medicine as an essential preparation for specialty training. Those who advocate such evaluation will be interested in recent happenings in Great Britain. After next January, every medical student in Great Britain, excepting Eire, who passes the qualifying examination will have to spend a year in internship in at least two different house services. He must take two different house positions of six months, as house physician, house surgeon, or obstetric house surgeon in a hospital approved by any one of the licensing bodies and designated in a list published by the General Medical Council. As soon as the new doctor obtains his internship he will be eligible for admission to the Provisional of the General Medical Council which confers upon him the full legal rights of a medical practitioner but only so far as is necessary in his position as an intern. After giving satisfactory service as an intern he is eligible for admission to the full Medical Register, and free to practice as he likes. There is no compulsion to start the intern year immediately on qualification, although it may be difficult for the new doctor to find a post later on. Furthermore, a man can remain on the Provisional Register as long as he likes. An effect which is predicted will be to increase the number of men available for these house staff positions and to ensure that they work in approved hospitals.

The first of these latter benefits would accrue in this country if general internships became similarly a universal practice. It would undoubtedly have effects in relieving the intern shortage now experienced by many hospitals. That specialism per se is concerned with all of medical education is obvious. Its intimate relation to postdoctorate training calls for consistent and continued appraisal. A

year of general medical training following graduation may hold educational advantages of highest values for any future medical career.

Diabetes Week

Diabetes Week, inaugurating the fifth annual Diabetes Detection Drive, has been set for November 16-22. The diabetes detection program under the auspices of the American Diabetes Association is following approximately the same pattern throughout the nation as in previous years. The tremendous growth of the Drive and its excellent reception by the medical profession is noteworthy.

Sponsored in this state by the Connecticut Diabetes Association in collaboration with the State Medical Society and the State Department of Health, the Diabetes Detection program has been supported in every community, and there has been a notable increase in response each year on the part of the public and the medical profession. It continues to be a doctor's program for public welfare with increasing physician interest and participation.

The Diabetes Detection Drive is an annual program for diabetes detection and education to discover diabetes early and to forestall diabetic complications. The unique feature of this nationwide effort is its continuation as a humanitarian drive for diabetes detection and not for public fund raising.

The World's Children

We are privileged to present in this issue Dr. Martha M. Eliot's address on the Health of the World's Children, given at the New England Health Institute on June 19. Dr. Eliot is an honored member of the Connecticut State Medical Society and a considerable part of her distinguished career was spent in New Haven as a member of the faculty of the Yale School of Medicine. It was here, as resident in pediatrics under Dr. Edward Park, that Dr. Eliot began her extensive community-wide investigation of rickets, which proved the high value of cod liver oil and sunlight as preventive agents. In 1924, while still at Yale, Dr. Eliot joined the Children's Bureau staff as director of the Division of Child and Maternal Health, and in the ensuing ten years maintained her residence in New Haven. In 1941 she was named associate chief of the Bureau. In June 1949 Dr. Eliot left the Bureau temporarily for a two year period as assistant director general of the World Health Organization, returning in 1951 to become chief of the United States Children's Bureau.

Connecticut Story

The PR Doctor, a publication of the Public Relations Department of the American Medical Association, carries a Connecticut story, "New Frontiers for County PR," in its issue of September 2, 1952. The progress of our public relations program is reviewed with emphasis given to the Society's leaflets "Main Street Frontier" and "Your Community—Your Future." The development of emergency call systems in Connecticut receives excellent comment as well as other features of our program. In itself, this recognition by our national organization is a deserved tribute to Dr. Barker, Mr. Burch, and the many others who are contributing to our program aimed at better public understanding.

Blue Cross Rates and Stabilization

Blue Cross membership fees have undergone change periodically. The increasing hospital costs of about 10 per cent each year and the increasing use of hospitals are direct causes for such change. The continuing upward movement of these costs demands that premiums must be established at rates which will hold as long as possible until change becomes a necessity. This holding measure is possible only through the use of accumulated reserves. Such reserves are greatly aided when low operating costs are maintained. In 1951 the operating costs of Connecticut Blue Cross were kept at 6 per cent of income (lowest in the country), favoring reserves for future use. In 1952 so far, with the pay-off to members of about 90 cents on any premium dollar, there promises to be but a small reserve cushion, if any. In spite of this, Blue Cross has promised no rate increase until August 1953, anticipating that at some time in 1953 outgo will probably exceed income, and that reserves accumulated in 1951 will have to be called on. The understanding of these simple insurance principles should make it plain to members how much skillful management with low operating costs mean in receivable benefits. The size of the management problem is impressive indeed—more than 8 million dollars paid out in benefits for 80,000 members in the first six months of 1952, the highest total for any six month period in the history of Connecticut Blue Cross. Some of this large sum went to hospitals in the other states and many foreign countries. Ninety-three per cent of the total, however, was paid directly to Connecticut institutions. Since its beginning in 1937, over 68 million dollars has been paid out, a striking record of accomplishment and a witness of the fact that

insurance on a voluntary basis not only works but satisfies a great public need.

Connecticut First

The people of Connecticut can be justly proud of the splendid record in maternity care for their State. In 1951 the maternal mortality rate for Connecticut reached a new low figure never equalled in this country or elsewhere. As recently as 1940 three mothers died for each one thousand live births, three times the rate in 1945 and thirty times the record low rate in 1951. In this issue of the JOURNAL Dr. Carl E. Johnson presents a five year study of Maternal Mortality and Morbidity in Connecticut for 1946-1950 inclusive. It is a story of fine achievement and has been brought about chiefly by awareness on the part of those responsible for maternal care that such improvements were possible. In fostering such awareness, highest credit must go to the Committee on Maternal Mortality and Morbidity of the Connecticut State Medical Society and the Bureau of Maternal and Child Hygiene of the Connecticut State Department of Health.

Dr. Johnson's report reflects the great time and labor given by these agencies to make our State the safest place in the world for childbirth.

Salute to Texas

News from Texas interests us for various reasons, not the least of which is to be found in the bonds of historical association between that great State and our own. The modern creators of Texas are said to have been Stephen F. Austin, who established there the first Anglo-American settlement, and the redoubtable Sam Houston. Stephen Austin was the son of Moses Austin, of Durham, Connecticut, who pioneered in the southwest and for a time actually sat in the Mexican parliament.

The present news tells us of the opening at Austin, Texas, of the new Memorial Library and the headquarters building of the Texas Medical Association, and a special section of the *Texas State Journal of Medicine*, September issue, is devoted to a description of this splendid new structure. Designed to serve more than 6,000 association members and over 4,000 auxiliary members, the building includes extensive library facilities and a lounge auditorium to seat 300. This modern new home, like our own, will further consolidate and strengthen the position of the state society as the all important link between the county associations and the national body. It will serve the high function of a state society in broadening sights beyond the local scene, thus helping medicine to take its proper place in state and national service. The new building is a splendid example of the Texas spirit in doing big things in a big way. Speaking of Texas bigness, a former governor of that state once said that Texas could wear Rhode Island as a watch fob. Perhaps he might find room for Connceticut in a vest pocket—over the heart. Texas Medical Association—we salute you!

The Objectives of The World Medical Association

Many physicians have been approached to become members of The World Medical Association and thus lend their support to the improvement of health conditions throughout the world. W.M.A. is an active organization, in fact, it is the only international organization of physicians which includes representatives from most of the nations outside the Iron Curtain.

Here are its objectives:

Promotion of closer ties among national medical associations and doctors.

Organization of an exchange of information on matters of interest to the medical profession.

Maintenance and protection of the honor and interest of the medical profession.

Study of and reporting on professional problems.

Raising the standards of medical education, medical care and health throughout the world.

Presentation of the world medical opinion to WHO and UNESCO.

PROGRESS IN CLINICAL MEDICINE

TULAREMIA IN CONNECTICUT

JOHN A. WOODWORTH, M.D., *Moosup*

WILD rabbits have usually been sought for by the clinician as the most common direct transmitting agent of tularemia to humans. While this is still justified by facts, other possible vectors should not be overlooked if initial errors in diagnosis are to be avoided. Greer and Keefer[1] recently reported on "cat-scratch fever," originally described by Foshay and gave an excellent review of the role of cats in the transmission of diseases to humans. Several authors[2-4] have reported tularemia infection by cat bites. That cat scratches may also result in infection with tularemia has not previously been emphasized and the case report which follows dramatically illustrates the enthusiasm with which a new disease entity may be considered in preferential diagnosis instead of differential diagnosis.

CASE REPORT

W. P., a white male aged 17, was admitted to the Day-Kimball Hospital on July 13, 1951 with chief complaints of chills and high fever of 2 weeks' duration and glandular swellings in the armpits of 9 days' duration.

On June 20, 1951 the patient had travelled from his home in Connecticut to North Carolina where he was to meet his fiancee and get married. Despite a history of two previous attacks of left otitis media in 1946 and 1951, respectively, he went swimming on June 22 in a resort lake. On June 23, he helped to catch several house cats in order to dispose of them by abandonment and at this time he was scratched on each index finger by one of the cats. These scratches were minor and not much attention was paid to them at the time. He went swimming again two days later. He was married on June 27 and that evening began to get a little feverish and to have pains in back of the left ear. At about this time, the exact date not being known, the patient began to notice a rash which started on the legs and spread to the buttocks, face, arms and trunk. On June 28, he experienced high fever, chills and general malaise but despite these symptoms, he began the return trip to his home in Connecticut by car, arriving the next day completely exhausted and having experienced headaches, chills, fever and pains in back of the left ear.

Following his return, the patient worked on his father's farm operating a milking machine and helping with the haying. On July 3, he first came to my office for treatment of his left ear which showed a recurrent purulent otitis media, the foregoing history not then being mentioned. On July 4, swelling and ulceration of the index fingers at the sites of the cat scratches began, associated with recurrence of severe general malaise and chilly sensations. From July 5 to July 8, the patient worked pitching hay, but finally had to stop because of painful armpits, chills and high fever. I saw him for the second time on July 9 when the cat scratch ulcerations of the index fingers were first brought to my attention, although the axillary glandular enlargement again was overlooked. The fingers were treated with Tyroderm cream and the patient was given 300,000 units of an aqueous suspension of procaine penicillin intramuscularly. On July 10 and 11 the patient felt a little better, but on the night of July 11, he had a fever of 103° and experienced a severe shaking chill with chattering teeth. The fever persisted and the patient finally returned to my office on July 13 and was hospitalized.

There was no history of exposure to rabbits and no history of tick bites. The patient's sister-in-law at the North Carolina residence had had malaria but did not experience an acute attack during or shortly before the patient visited there. In February 1951 he was treated for acute recurrence of the left ear infection with subsidence of the process. As far back as 1946 the patient had been found to have a 60 per cent loss of hearing in the left ear. The only other previous illnesses were chicken pox, measles, mumps and whooping cough. There was a family history only of asthma in the father and a paternal grand-aunt had died of cancer at the age of 85.

Physical examination at the time of admission to the hospital showed a temperature of 102° F., pulse rate 80 per minute, respiratory rate 16 per minute and blood pressure 130 systolic, 80 diastolic. The patient was a well developed and well nourished young adult white male lying quietly in bed and not appearing acutely ill. The skin showed numerous small furuncles scattered over the buttocks, legs, arms, anterior surface of the trunk, and a few scattered lesions on the face. These varied in size from 0.5 to 2 mm. in diameter. The skin of the dorsum of the proximal phalanx of each index finger showed an ulceration of about 1 cm. in diameter with a crater-like center filled with purulent necrotic exudate and a raised dull-red periphery. The ulcerations were extremely tender. No radiating red streaks from these areas were seen. Examination of the head and eyes showed normal findings. The left eardrum was distorted by previous infection, slightly red, partly covered with dry exudate and still contained a small amount of a white powder insufflated

Presented at the Staff Meeting of the Day-Kimball Hospital, Putnam, June 3, 1952

several days prior to hospitalization. The right eardrum was normal. There was slight deviation of the nasal septum to the right with partial obstruction. The mucous membranes of the pharynx were slightly inflamed. The mouth, teeth, tongue and tonsils were normal. The neck showed no rigidity, the trachea was in the midline, the thyroid was not palpably enlarged. The thorax was without deformity and respiratory excursions were symmetrical. The lungs were normal on palpation, percussion and auscultation. Examination of the heart showed no evidence of enlargement on percussion. The heart sounds were of good quality and intensity, and were regular in rate, rhythm, and force. There was a grade I systolic blowing murmur heard best along the left border of the sternum. The second aortic area sound was slightly louder than the second pulmonic area sound. The abdomen was soft and non tender and there were no palpable masses. The spleen was thought to be barely palpable on deep inspiration but was not tender. The liver was not palpable. The back showed no deformity or tenderness. The extremities were normal except as previously noted. The vascular system, including the lymphatics, was normal with the exception of the axillary regions. In each axilla, there was a large, extremely tender, indurated lymph node about the size of a small plum. Neither showed any evidence of fluctuation. Examination of the nervous system showed normal active deep and superficial reflexes. There were no sensory or muscular changes and no abnormal responses.

Laboratory studies showed an hematocrit reading of 49, hemoglobin 90 per cent, white blood cell count 9,600 per cu. mm. with 69 per cent neutrophiles and 31 per cent lymphocytes. Urinalysis showed a clear yellow urine with a specific gravity of 1.022, pH 5.0, negative for albumin and sugar. Microscopic examination of the urine was negative. A single blood smear was examined for malarial parasites and was reported as negative. Venous blood was collected and sent to the Connecticut State Department of Health Bureau of Laboratories for agglutination reactions on July 16.

The patient was treated with 500 mg. of terramycin every six hours and hot packs were applied discontinuously to the axillary regions. There was almost immediate improvement. His temperature dropped abruptly from 102° to 99° within 12 hours and remained between 98.2° and 99.6° orally during the first four hospital days. During the 24 hours prior to discharge, his temperature was normal. The axillary nodes regressed rapidly without surgery. The finger ulcerations were treated with aureomycin ointment (terramycin ointment was not immediately available), and showed progressive healing. Subjectively, the patient felt much better, and, on his insistence, he was discharged on the fifth hospital day to continue terramycin by mouth for several more days as an outpatient. He has remained well during the ten months since discharge.

This patient was thought to have "cat-scratch fever" and Dr. Lee Foshay of the University of Cincinnati was contacted and kindly sent a vial of cat-scratch disease antigen by air mail. However, on the day of its arrival, the mail brought a report from the Bureau of Laboratories on the blood agglutination tests. The patient's blood was negative for agglutination with Leptospira icterohemorrhagiae, Leptospira canicola, Typhoid O and H, Paratyphoid A and B, and for Brucella organisms. However, tests against B. tularensis were positive 4 plus up to a dilution of 1:640. Complement fixation tests for epidemic typhus, rickettsial pox, Q Fever, and Rocky Mountain spotted fever were negative. Blood clot cultures for salmonella and brucella were negative.

REVIEW OF TULAREMIA CASES IN CONNECTICUT

This disease was discussed with Dr. James C. Hart, director of the Bureau of Preventable Diseases of the Connecticut State Department of Health, who very kindly provided the following abstracts of all the cases of tularemia which have been reported to the State Department of Health since the disease was first made reportable in 1928:

I. C. M., male, age 49, of East Hampton, Connecticut went hunting on November 23, 1940. He shot two rabbits and picked up another which he felt had broken its neck. He skinned the rabbits on November 25, 1940. They were cooked and eaten November 27, 1940. On November 28, Mr. M. developed malaise, chills, headache and fever. Ulcers on the third finger of each hand were noted at this time. He was treated at home until December 9, 1940 when he was admitted to the Newington Veteran's Hospital where he died on December 14, 1940. An autopsy was performed. Blood collected December 10, 1940 showed tularemia agglutinations as follows: 20, 0; 40, ±; 80, +; 160, 2+; 320, 3+; 640, 4+.

II. M. B., female, age 63, of Columbia, Connecticut, was bitten on the hand by a kitten on September 8, 1941. On September 18, 1941 patient developed malaise, chills, headache and nausea. An ulcer was present on the dorsum of her left hand and she had palpable tender epitrochlear and axillary nodes. She was admitted to the Windham County Memorial Hospital on September 22, 1941 and died on September 30, 1941. An autopsy was performed. Blood taken on September 29, 1941 showed tularemia agglutination of 4+, 4+, 4+, 4+, 4+, 4+. The kitten which bit Mrs. B. was taken to Dr. Jungherr at the University of Connecticut and was found to have lesions typical of tularemia as well as positive agglutinations. Another kitten from the same litter also had positive agglutinations.

III. Mrs. M. E. of Stamford, Connecticut was given a rabbit by some friends on November 12, 1941. On November 16, 1941 she cut it up and cooked it. About November 20, 1941 she developed a "cold" and a pain in the left axilla. She also had a slightly raised red area with pinhead ulceration on the middle finger of her left hand. She first saw a physician on November 28, 1941. Two blood samples were taken for tularemia agglutinations. They showed: 12-3-41: 2+, 2+, +, 0, 0, 0; 12-10-41: 2+, +, ±, 0, 0, 0. The patient was not hospitalized and she recovered rapidly.

IV. T. Y., male, age 51, of Glastonbury, who worked in the Navy recruiting service, was admitted to the hospital at Bradley Field, Windsor Locks on July 1, 1945. He died there on July 5, 1945 and the cause of death was entered on the death certificate as primary atypical pneumonia. A letter from the A.A.F. Regional Station Hospital, Army

Air Base, Westover Field, Massachusetts written December 4, 1945 was later received and read as follows:

"In the case of C.P.O. T.Y. who died at Bradley Field on July 5, 1945 the cause of death was entered on the death certificate as primary atypical pneumonia. In the light of investigations carried out since that time the probable diagnosis is tularemia. Bacteriological studies were inconclusive but the Pathology Department at the Army Medical Museum agreed with us that the clinical picture and histological findings were consistent with the diagnosis of tularemia."

No further history and no possible source of infection are known in this case.

V. H. B., male, age 46, of Preston, Connecticut went hunting on December 12, 1945 and killed three rabbits which he skinned immediately. On December 16, 1945 he developed grippe-like symptoms and small ulcers on his right thumb and middle finger. On December 19, 1945 because of his grippe and painful swollen glands in the right axilla he consulted a physician. He was treated with sulfadiazine. On December 24, 1945 because he continued to have fever he was started on penicillin. A blood specimen collected December 29, 1945 showed tularemia agglutinations of 4+, 4+, 4+, 4+, 4+, 4+. The patient was not hospitalized and he made an uneventful recovery.

VI. K. P., female, age 46, of Groton, Connecticut owned a cat which on April 21, 1949 caught and killed a rabbit. Within a few days the cat became ill and on May 1, 1949 it died in Mrs. P.'s arms. Just before death the cat clawed Mrs. P. near the base of the left thumb. On May 3, 1949 Mrs. P. developed fever and on the following morning noted swelling and pain in the left axilla. She was treated at home with penicillin, sulfa drugs and aureomycin and recovered from her febrile episode. She was admitted to the Lawrence and Memorial Hospital in New London on May 23, 1949 for incision and drainage of an abscess in the left axilla. Biopsy of the axillary nodes was diagnosed by the pathologist as being characteristic of tularemia. She was discharged from the hospital on May 27, 1949. Blood taken during her hospitalization showed tularemia agglutinations of +, 2+, 3+, 4+, 4+, 4+. Blood taken from a second cat owned by Mrs. P. which had been "off its feed" at the time the first cat died was examined at the University of Connecticut and was reported as agglutinating tularemia organisms in dilutions up to 1:200.

DISCUSSION

It is evident from this review that of the seven cases of tularemia known to have occurred in Connecticut, three resulted from contact with cats; and of the three, two were due to cat scratches. Three cases resulted from the handling of rabbits, and in one case the mode of transmission is unknown. It is further evident that where a history of cat bite or cat scratch precedes the onset of ulcerations at the site of injury, regional lymphadenitis, fever, chills and possibly a generalized skin eruption—the differential diagnosis must include tularemia as well as the other diseases most commonly confused with it: cat scratch disease, tuberculous adenitis, lymphogranuloma venereum, infectious mononucleosis, sarcoidosis, sodoku and Hodgkin's disease.[5]

It is noteworthy that all of the reported Connecticut cases have occurred since 1940, and that three of these seven cases died, giving a mortality rate of 43 per cent. In 1938 United States Public Health Service figures showed a mortality rate of 4.8 per cent but Foshay (1937) believed that the number of tularemic deaths escaping recognition is sufficient to bring the true mortality up to 6 per cent.[6] At that time therapy was supportive and non specific, although Foshay's antiserum seemed to modify the course of the disease. That the disease varies considerably in its virulence is emphasized by a report by Glass[7] of a mortality rate of 1.7 per cent in an epidemic of 121 cases he observed in Siberia in 1941; and there was a high incidence of signs of meningeal involvement in that series. With the advent of streptomycin, a highly effective therapeutic agent became available and continues, with dihydrostreptomycin, to be the drug of choice.[8] The less toxic chloromycetin, aureomycin and terramycin have been reported effective in causing remission of the disease[9] but recent work by Corwin and Stubbs tends to cause doubt that they are curative or as effective as streptomycin and dihydrostreptomycin.[10] The case reported would seem to confirm the prompt efficacy of terramycin when used late in the course of the disease.

Connecticut's experience of a high mortality rate from tularemia emphasizes the need for an alert awareness of its occurrence in this State, and a high index of suspicion in any case presenting this symptom-complex of chills, high fever, solitary ulcerative skin lesions, regional lymphadenitis, and a generalized eruption. Since this is a preventable disease, and since we now have highly effective therapeutic agents, death from tularemia should become a rarity.

SUMMARY AND CONCLUSIONS

Tularemia, though of low incidence in the State of Connecticut, has been associated with a case fatality rate of 50 per cent, six cases with 3 deaths having been reported to the State Department of Health since the disease was first made reportable in 1928. A seventh case is described having the unusual feature of transmission by cat-scratches, and leading to an erroneous diagnosis of "cat-scratch fever." The use of terramycin by mouth in this patient was associated with prompt recovery. The

six previous cases of tularemia are briefly summarized, and the literature briefly cited to emphasize mode of transmission, differential diagnosis, mortality rate and treatment.

The following conclusions therefore seem warranted:

1. Tularemia is commonly transmitted by the bite or scratch of cats which have been in contact with wild rabbits, and may thus be confused with "cat-scratch fever" in addition to other longer known disease entities.

2. Terramycin by mouth in one patient was associated with prompt recovery.

3. Tularemia, though an unusual disease in Connecticut, has killed 43 per cent of those afflicted with it in this State.

4. Connecticut physicians should be alert to the occurrence of this disease in order that this shamefully high mortality rate may be reduced to a minimum.

BIBLIOGRAPHY

1. Greer, W. E. R., and Keefer, C. S.: Cat-scratch fever, New England J. Med. 244:545-548, April 12, 1951.

2. Chambers, W. E.: Human tularemia infection through bite of domestic cat, M. Bull. Vet. Admin. 19:206, 1942.

3. Rudesill, C. L.: Tularemia from bite of nursing kitten, J. A. M. A. 108:2118, 1937.

4. Cecil, R. L.: Textbook of Medicine, Fourth edition, W. B. Saunders, Philadelphia, 1937.

5. Editorial, Cat-scratch disease. J. A. M. A. 147:746-7, March 1, 1952.

6. Beckman, H.: Treatment in General Practice, Third edition, p. 220, W. B. Saunders Co., Philadelphia, 1940.

7. Glass, G.: Tularemic meningismus and serus meningitis, Med. Clin. No. Amer. May 1948:769-778.

8. Keefer, C. S. et al: Nat. Res. Council, J. A. M. A. 132:4 September 7, 1946.

9. Conn, H. F.: 1952 Current Therapy, W. B. Saunders Co., Philadelphia.

10. Corwin, W. C., and Stubbs, S. P.: Further studies on tularemia in the Ozarks, J. A. M. A. 149:343-345, May 24, 1952.

Diabetes Detection and Education Program

This program, planned for November 16 to 22 of this year, is endorsed by the State Medical Society and its component parts.

By those who study statistics, it has been estimated that of each 140 persons, one has diabetes and is under treatment, another has the disease and does not know it, and two others will contract it before they die. The November drive is to aid in finding the undiagnosed and new cases before damage has been done by the disease. Mild diabetes is often diagnosed by the ophthalmologist or surgeon by the damage it has produced before its symptoms are severe enough to inconvenience the patient.

This delay can be shortened by alertness of the family doctor and resultant changes minimized. Early treatment is urgently needed as the uncontrolled diabetic always becomes worse.

The finding of sugar in the urine is abnormal and must never be taken lightly. A blood sugar should be taken at that time for confirmation—waiting till the next morning means that the blood sugar is lowered by fasting and the patient is already on a diet.

A glucose tolerance is needed only when the blood sugar is in the doubtful range and requires that the patient be on a full diet without carbohydrate restriction for three days before the test is made.

Any doubtful cases should be observed by having the patient do a test for urinary sugar at home two hours after the main meal daily for a week or twice a week for a month. Most patients will cooperate willingly when they understand the need for testing and its place in diagnosis.

It is hoped each doctor will cooperate in the drive by testing for sugar each patient seen that week and by urging their diabetic patients to test the urine of each member of their families.

New Haven GP's Hold Meeting

The Annual Meeting of the New Haven County Chapter of the American Academy of General Practice was held at the Castle Memorial Building, 30 Central Avenue, Waterbury, on September 24, 1952.

The new president, John C. Carrozzella, Wallingford, was installed.

The following officers were elected for 1952-53: President-elect, Rudolph A. Damiani, Waterbury; Secretary-Treasurer, Richard B. Elgosin, Hamden; Delegates: Theodore R. Lovelace, Waterbury, and Evan J. Whalley, Waterbury; Board of Directors for three years, Ralph DeCristoforo, Waterbury; Councilor, Jacob I. Gancher, Waterbury.

THE PRESIDENT'S PAGE

The Ninth Annual Conference of the Woman's Auxiliary to the American Medical Association will meet in Chicago November 6 and 7. The theme of the conference will be, "Our Goal—A Better World." Such an exalted goal has been sought by many individuals as well as by groups, none having a greater desire to accomplish their mission than this aggregation of earnest women.

The Woman's Auxiliary was organized for the purpose of promoting the sale of *Hygeia*, (now *Today's Health*). Many other planned undertakings have been assumed by the Auxiliary since its foundation, all directed to aid, to support and to assist the American Medical Association in the promotion of the science and art of medicine and the betterment of the public health. Not the least of these projects has been the task of learning more about the problems that beset the doctor and more specifically the problems that confront their own doctor husband.

Like good democratic government, the Auxiliary functions best when its efforts are kept small and as local as possible in character. The small county groups are the important units of the Auxiliary and it is at this level that the greatest good has been achieved. It has been said that there are two ways of spreading light: to be the candle or the mirror that reflects it. The Auxiliary has been pleased to accept the role of the mirror in reflecting the light of health education as provided by organized medicine under the American Medical Association. It may be that the light reflected from this mirror can be directed to areas not illuminated by the candle source of light.

The Woman's Auxiliary has won the respect and the gratitude of the Connecticut State Medical Society for the aid and the cooperation given to the doctors of the State in a mutual effort to bring the benefits of health education to our people.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

THE MISSING PRESIDENTS

There have been 115 presidents of the State Medical Society since it was founded in May 1792. About two years ago a plan was launched to obtain pictures of these distinguished gentlemen, and now all but 13 have been found and copied in standard format and are in portfolios in the secretary's office. Ultimately it is planned to frame them in a continuous panel in a corridor of the Society building. Early work on this interesting project was done by Mrs. James Douglas Gold, of Bridgeport, who was responsible for collecting 30 or 40 of the pictures. During the last year it has been carried on from the secretary's office and many members of the Society have cooperated and to them we are all grateful.

The missing 13 are mentioned here with some detail in the hope that from the information given some member may find a clue of family connection or historical publication that will lead to the discovery of the pictures still to be found.

LEVERETT HUBBARD, the first president of the Society, was a native and highly regarded citizen of New Haven. He was usually spoken of as Colonel Hubbard because of his military service prior to the Revolution. It seems remarkable that there is not a portrait of Colonel Hubbard somewhere because for a time he was among the most prominent citizens of Connecticut. A search for his picture has been under way by the Society for ten years as it was hoped to have the picture for display at the time of the Society's sesquicentennial in 1942. It is likely that there are descendants of Leverett Hubbard around the New Haven area.

JAMES POTTER, president in 1801, was a leading citizen of Fairfield County. He practiced medicine in the Sherman-New Fairfield area, was often a member of the Connecticut Legislature and a biographer has characterized him as a "social figure." It is possible that a portrait, an engraving, or a wood cut might be found in some historical archives in Fairfield County. He is believed to have been a relative of the famous Jared Potter of Wallingford.

THOMAS MOSELEY, who was president in 1803, originated in Glastonbury and practiced in East Haddam. He graduated from Yale College in 1751 and married twice. His first wife was Phoebe, the daughter of Jonathan Ogden, the Governor of New Jersey in 1759 and his second wife was the widow of Governor Throop of Connecticut and the daughter of Governor Matthew Griswold. He had one son by his first wife, Jonathan Ogden Moseley, a lawyer and a member of the United States Congress from Connecticut for twenty years. When he died in 1811 Dr. Moseley left his medical library to his friend Dr. Richard Ely.

JEREMIAH WEST of Tolland, was president in 1804. He graduated from Yale in 1774. He married three times and has a number of descendants.

WILLIAM BUEL, president in 1832, was the beginning of a line of physicians of that name to reside in Litchfield. He was a well known citizen and it is surprising that a picture of him has not yet been found in the rich historical area of Litchfield County.

THOMAS MINER, of Middletown, one of Connecticut's best known early physicians was president in 1834. He was a great scholar and colaborated with William Tully in the authorship of the famous book on therapeutics. Sketches of Dr. Miner are included in a number of volumes of American medical biography, but so far no picture of him has been found.

LUTHER TICKNOR came from Jericho, Vermont, and was the brother of Benajah Ticknor, a surgeon in the United States Navy. He received his degree

from the Berkshire Medical College, Pittsfield and practiced in Salisbury where he married Eliza Lee, the daughter of Elisha Lee. He died in April 1846.

Nathan B. Ives was one of a number of doctors of that name who practiced in New Haven. He was president in 1865.

Ira Hutchinson came from Cromwell and was president in 1873.

Charles M. Carleton was a well known practitioner in Norwich. He was president of the Society in 1878 and died in 1886.

Elisha B. Nye, president in 1883, was born in Sandwich, Massachusetts, attended Wilbraham Academy at Wilbraham, and graduated from Wesleyan University, Middletown, in 1831. He studied medicine with Eli and Nathan B. Ives in New Haven and received his M.D. from Yale in 1837. He first settled in practice in Moodus and removed to Middletown in 1851. He served for many years on the Board of Education in Middletown, was a councilman and alderman, a trustee of the Connecticut State Hospital and of the Middletown Savings Bank, the Connecticut Mutual Insurance Company and the Middletown National Bank. One of his avocations was investigation of the famous "Moodus Noises."

Elijah C. Kinney practiced for many years in Norwich. He was president in 1885 and died in 1892.

Francis D. Edgerton was long identified with medical affairs in Middletown. He served as president in 1892.

These are the presidents whose pictures are needed to complete this great collection which is invaluable.

Report On AMEF Campaign in Connecticut

October 20, 1952

Total pledged or contributed	$9,863.00
Number of contributors and pledgers	194
Number indicating direct payments to their medical schools	201
Number contributing directly to AMEF Chicago	1
Cash transmitted to AMEF	$9,863.00

COUNTY BREAKDOWN (including those contributing directly to their medical schools):

Hartford County	120	Litchfield County	20
New Haven County	99	Windham County	19
Fairfield County	90	Tolland County	3
New London County	23		
Middlesex County	22		395

(Connecticut is fifth state in number of conrtibutors, eighth in amount of funds raised.)

New Members

FAIRFIELD COUNTY

Malcolm S. Beinfield, Westport
Miriam B. Blank, Bridgeport
Frederick J. Christie, Shelton
Thomas H. Connell, Jr., Bridgeport
Noel L. Conrade, Norwalk
Forbes Delany Greenwich
Poul M. Faergeman, Stamford
John W. Gerster, Greenwich
Joseph Hamburg, Stamford
Norman E. Jarvik, Glenbrook
Salvatore LaCorte, Stamford
Edmund D. Marinucci, South Norwalk
Rudolph J. Marshall, Jr., Bridgeport
John F. McGarry, Stratford
John P. Murphy, Riverside
Edward M. Pullen, New Canaan
Joseph Reiss, Newtown
Norman Righthand, Stamford
Hardin Ritchey, New Canaan
James E. Ryan, Bridgeport
St. Clair G. Strong, Norwalk
John L. Sullivan, Bridgeport
Frederick D. Williams, Stamford

NEW LONDON COUNTY

Robert D. Hayes, Norwich
Joseph E. Milone, Norwich
Louis P. Saxe, Niantic
Isadore Selzer, Norwich

LITCHFIELD COUNTY

Jeffrey Ferris, New Milford
Thomas M. Hart, Washington Depot
Margaret Stanley-Brown
Francis E. Tierney, Pleasant Valley

MIDDLESEX COUNTY

Donald Arnault, Middletown
Herbert Levine, Middletown
Alfred Owre, Madison

Elections in Hartford, New Haven, Tolland and Windham Counties will be announced in December.

Meetings Held in October

October 2—Sub-Committee on School Health of the Committee on Public Health

New London County Medical Association Meeting

October 7—Committee on Hospitals
Committee to Confer with the State Department of Welfare
Litchfield County Medical Association Meeting

October 8—Committee to Study Maternal Mortality and Morbidity
Committee to Study Respirator Treatment Center
Governor's Commission to Study Medical Education

October 9—Middlesex County Medical Association Meeting

October 16—Windham County Medical Association Meeting

October 21—Tolland County Medical Association Meeting

October 22—Sub-Committee on Neonatal Infant Mortality of the Committee on Public Health

October 23—Council

October 27—Committee on Volunteers for Connecticut Heart Association

October 28—Hartford County Medical Association Meeting

October 29—Committee on Industrial Health
Governor's Commission to Study Medical Education

October 30—New Haven County Medical Association Meeting

CONNECTICUT PLAN FOR MEDICAL CARE OF VETERANS

Agreement Between the Veterans Administration and The Connecticut State Medical Society for the Medical Care of Veterans With Service Connected Disabilities

The Connecticut State Medical Society (hereinafter called the "Contractor") and the Veterans Administration for the purpose of establishing and maintaining a close working relationship in order to establish a well integrated service for providing medical care and treatment for veterans in the State of Connecticut beyond those services available to the Veterans Administration in existing Veterans Administration facilities and installations, do hereby mutually agree as follows:

1. SERVICES

The Contractor will request all of its members (citizens of the United States who are doctors of medicine duly licensed to practice medicine or surgery in the State of Connecticut) to participate in a State-wide program whereby physicians in private practice in the State of Connecticut will render medical services (examinations, treatments and counsel) in such cases as may be specifically authorized by the Chief Medical Officer of the Veterans Administration Field Station having jurisdiction, or his designate; the physician reserving the right, however, to decline any particular case.

2. MEMBERSHIP

a. The contractor will submit semi-annually to the Veterans Administration a list of its members who desire to provide service for eligible veterans in the home communities of such veterans. The physicians so listed will be fee basis physicians of the Veterans Administration. By notice in writing, a physician may at any time request that his name be removed from the list of fee basis physicians.

b. Lists of physicians submitted by the contractor will be broken down by counties or districts in order that the veterans for whom services are authorized may select a physician practicing in his home community.

c. The contractor will also assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications for specialist of the Veterans Administration.

3. ADMINISTRATIVE AND CLERICAL DETAILS

The Veterans Administration will handle administrative and clerical details in connection with the authorization of examinations or treatments and the maintenance of records; and will arrange for transportation of the veteran if necessary.

4. ELIGIBILITY OF VETERANS

The Chief Medical Officer of the Veterans Administration Field Station having jurisdiction, or his designate, shall determine eligibility of each veteran for examination, treatment or counsel, and shall issue authorizations for same to the individual physicians.

5. VETERANS' CHOICE OF PHYSICIAN

For examination, treatment or counsel, a veteran may choose any professional member of the con-

tractor who practices in the community in which the veteran resides. The Veterans Administration will advise the veteran of his privileges hereunder.

6. EXAMINATIONS FOR RATING PURPOSES

The choice of physician by the veteran is not applicable to examinations for pension or compensation rating purposes. Examinations for such purposes may be made by member physicians of the contractor only when specifically designated by the Chief Medical Officer of the Veterans Administration Field Station having jurisdiction, or his designate. The physician will be ineligible to conduct an examination for pension or compensation rating purposes, if he has treated the examinee within the preceding three (3) months, or has submitted an affidavit or statement in connection with the veteran's claim.

7. REPORTS

The Chief Medical Officer of the Veterans Administration Field Station having jurisdiction, or his designate, will review reports of services (including examinations) to determine their adequacy. No fees will be paid by the Veterans Administration for reports which are not acceptable to the Veterans Administration or for services rendered in unauthorized cases.

8. BOARDS OF REVIEW

The contractor will establish one or more boards of review composed of physicians. The names and addresses of physicians comprising the Board or Boards of Review will be furnished the Regional Office concerned. Any changes in the membership should be reported to the Veterans Administration as soon as possible. It shall be the duty of such Board to review reports, which are deemed by the Veterans Administration to be inadequate or which do not meet the requirements of the Veterans Administration; to recommend, at its discretion, the disqualification of any physician for further work with the Veterans Administration whose work is found by the Board to be incomplete or unsatisfactory; to advise and assist the Veterans Administration on other matters within the scope of this program.

9. FEES

Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the Fee Schedule hereto attached, which is made a part of this agreement. It is mutually understood that the fees stated in the Fee Schedule represent the maximum amount that may be charged, and do not represent the amount to be paid in every case. The Veterans Administration will advise each physician of this provision and will require each physician to certify in submitting his statement of account that the fees charged are not in excess of the fees charged by him for comparable service rendered non veterans. It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by the contractor to the Central Office, Veterans Administration, which will determine the appropriate fee.

10. ADJUSTMENT OF FEES

It is agreed that any item in the Fee Schedule which is mutually found to be inequitable may be increased or decreased after review and final determination to that effect by the Contracting Officer of the Veterans Administration, but that such increase shall apply only to services authorized and rendered after such determination.

11. CONTRACTUAL RESERVATION

Nothing in this agreement shall preclude the right of the Veterans Administration to enter into contracts or agreements with other organizations or individuals in the State of Connecticut for providing medical care to eligible veterans.

12. PERIOD OF CONTRACT

This agreement shall be effective from July 1, 1952 to June 30, 1953.

13. RENEWAL CLAUSE

This agreement, if mutually satisfactory may be renewed for periods of one (1) year, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal.

14. TERMINATION

This agreement may be terminated by either party by giving thirty (30) days' written notice to that effect.

15. CONTINGENT FEES CLAUSE

The contractor warrants that no person or selling agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or

bona fide established commercial or selling agencies maintained by the contractor for the purpose of securing business. For breach or violation of this warranty the Government shall have the right to annul this contract without liability or in its discretion to deduct from the contract price or consideration the full amount of such commission, percentage, brokerage, or contingent fee.

The bidder represents that he has not employed or retained a company or person (other than a full time employee) to solicit or secure this contract, and agrees to furnish information relating thereto as requested by the Contracting Officer.

16. OFFICIALS NOT TO BENEFIT

No Member of or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this agreement or to any benefit that may arise therefrom, unless it be made with a corporation for its general benefit.

17. NON DISCRIMINATION IN EMPLOYMENT

The contractor agrees that in performing this agreement, it will not discriminate against any employee or applicant for employment because of race, creed, color, or national origin, and that it will include a similar provision in all agreements entered into by it to effectuate this agreement.

18. DISPUTES CLAUSE

Except as otherwise specifically provided in this agreement, all disputes concerning question of fact arising under this agreement shall be decided by the Contracting Officer, subject to written appeal by the Contractor within thirty (30) days to the head of the department concerned or his duly authorized representatives, whose decision shall be final and conclusive upon the parties hereto.

The contractor does not propose to make any charge for any service rendered to the Veterans Administration under this agreement.

Connecticut State Medical Society,
By Samuel B. Rentsch, M.D.,
Chairman of the Committee of the
Connecticut State Medical Society
for the Care of Veterans

Approved and accepted, Veterans Administration.
To renew contract V1001M-81.

By A. J. Harrison,
Chief, Procurement Division

Fee Schedule for Medical Services

THE TWO PARTS OF THE FEE SCHEDULE

In order to achieve uniformity and to expedite negotiations between Veterans Administration and state medical associations or state medical service organizations concerning fee schedules, the Veterans Administration requests that such fee schedules be submitted on this prepared form in two parts:

Part I consists mostly of outpatient services to be rendered in the physician's office, veteran's home or hospital.

Part II is made up principally of items relating to inpatient services.

The reason for the separation of the total schedule into parts is to permit the shorter, more frequently used and more urgently needed Part I to be quickly submitted, accepted and put into operation while the longer and more difficult Part II is being negotiated.

NUMBERING OF ITEMS

For purposes of identification, all items of the fee schedule form are numbered. Some items are listed twice. This is done when items may be sought under more than one classification heading. Thus, "Blood Wassermann" may be found under both "Clinical Laboratory Tests" in Part I and under "Examinations—Blood" in Part II. However, it will be noted that to secure identification of the item as the same in both cases, the same number is assigned to each entry. For this reason the numbers are occasionally out of consecutive order.

AA

Minimum and maximum fees will be shown for each "AA" item. The fee for a given "AA" service will be determined by arbitration and agreement between Veterans Administration and the concerned state medical association or state medical service organization.

CONSULTATIONS AND EXAMINATIONS BY SPECIALISTS

Examinations by specialists (pp. 3 and 4) are differentiated from normal consultations by specialists (p. 5). Authorizations by Veterans Administration for fee basis physicians or specialists to furnish medical service to veterans are executed on either (old) VA Form 2639 (Revised April 1944) or VA Forms 10-2567 or 10-2568 (November 1946). Each form shows a space for "Nature of Service Authorized (or Required)" and another for the "Fee

Authorized" for the service in question. Fees for formal consultation will be allowed only when consultation rather than examination by a specialist is specifically authorized. Consultations will be authorized only when previous efforts to arrive at a definite diagnosis have failed.

As a general policy, specialists will only be authorized to conduct examinations covering their particular specialty. If, however, a specialist is authorized to conduct a complete physical examination concurrently with an examination covering his specialty, his fee for the two concurrent procedures will be the greater fee plus one half of the smaller fee.

EXAMPLES

A cardiologist authorized to conduct an examination of the heart, including an electrocardiogram (Item 0026), and who is also authorized to conduct a complete physical examination (Item 0012) will be paid a fee of $15 (Item 0026) plus $3.75 (one half of Item 0012), or a total fee of $18.75.

NOTE

The foregoing is not applicable to laboratory or x-ray services. Fees for these services will be in accordance with the actual number of services performed at prices listed in the Fee Schedule for each item except as otherwise specified in Fee Schedule (see Item 0012, page 3, and Item 9107B, page 19).

STANDARDS FOR NEUROPSYCHIATRISTS TO BE DESIGNATED FOR THERAPY

PSYCHIATRISTS

Qualifications:

a. Certified in psychiatry by American Board of Psychiatry and Neurology, or

b. Possession of one of following ranks in an accredited Medical School.

1. Any professorial rank in psychiatry.

2. Associates in psychiatry.

c. Experience:

1. At least four years of two half days a week in an accredited Mental Hygiene Clinic or similar institution in which modern therapeutic principles and techniques were practiced, or

2. Certification by the American Psychoanalytical Association and four years' practice of psychiatry using this, or other, forms of modern psychiatric treatment, or

3. Two years' certified training and experience in the Armed Forces or in any other accredited institution in which intensive individual therapy was practiced and taught, with two additional years of similar practice, either private or institutional.

NEUROLOGISTS

Qualifications:

a. Certification in neurology by American Board of Psychiatry and Neurology.

STANDARDS FOR SPECIALISTS OTHER THAN NEUROPSYCHIATRISTS TO BE DESIGNATED FOR THERAPY AND FOR NEUROLOGISTS AS INDICATED ABOVE

1. Certification by the appropriate Specialty Board: or in lieu thereof.

2. Specialists not possessing Specialty Board Certificates—

(a) At least four years experience in a given specialty (including recognized residency) and

(b) At least 50 per cent of practice devoted to a given specialty, and

(c) Recognized as specialist by the Medical Association or Society in the State in which he practices.

Fee Schedule for Medical Services
Part I

CLINICAL LABORATORY TESTS

0001—Red, white and differential blood counts including instrumental colorimetric hemoglobin estimation	$ 5.00
0002—Blood smear for malaria	2.00
0003—Urinalysis, routine chemical and microscopic	2.00
0004—Blood Wasserman (complement-fixation)	3.50
0005—Blood Kahn (precipitation)	2.50
0006—Venepuncture and procuring of blood for serology without serological examination	1.00
0007—Spinal fluid Wasserman (complement-fixation)	3.50
0008—Chemical examination of blood complete, including creatinin, urea, dextrose, nitrogen (or NPN) and uric acid	15.00
0009—Sputum examination for tuberculosis (plain smear)	2.00
0010—Determination of basal metabolic rate	5.00

VISITS AND EXAMINATIONS

0011—Office, home or hospital visits, including examination to determine need of hospitalization:

Visits within city limits:

*Day

Office 3.50
Home 4.00
Hospital 4.00

*Night

Home 7.00
Hospital 7.00

*Day: 8:00 A. M. - 7:00 P. M.
*Night: 7:00 P. M. - 8:00 A. M.

0012—Complete general routine physical examination including routine urinalysis (chemical) 7.50

0023—Charge for mileage one way for day or night visit outside city limits in addition to appropriate fee ..... .75

EXAMINATIONS BY SPECIALISTS

0024—General surgical 5.00
0025—Orthopedic 7.50
0026—Complete examination of heart, including electrocardiogram 15.00
0027—Electrocardiogram with interpretation 10.00
0028—Physical examination of lungs 10.00
0029—Roentgenological study of chest 10.00
0029A—X-ray lungs stereoscopic 15.00
0030—Gastrointestinal, including barium meal and enema, x-ray and fluoroscopy with preliminary KUB film 35.00
0031—Dermatological 5.00
0032—Allergy investigation including history, physical examination, relevant laboratory procedures (skin tests, smears of sputum and nasal secretions, vital capacity, etc.) and report 25.00
0033—Diagnostic skin tests only, intradermal or scratch, 40 extracts 15.00
0034—Each additional intradermal or scratch test ..... .25
0035—Genitourinary examination without cystoscopy including prostatic smear and urinalysis 10.00
0036—Genitourinary examination with cystoscopy 25.00
0037—Gynecological 5.00
0038—Proctological (rectal speculum) 7.50
0039—Psychiatric examination (first hour or less) 10.00
0039A—Major portion of each additional half hour 5.00
0040—Neurological examination (first hour or less) 10.00
0040A—Major portion of each additional half hour 5.00
0041—Examination of ears, nose and throat 5.00
0042—Special ear examination, including audiometric test with chart 10.00
0043—Special ear examination, including caloric or Barany test with audiogram and report 15.00
0044—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, as well as a report of abnormalities found 10.00
0045—Examination of eyes with refraction, manifest or cycloplegic, to include either a copy of the prescription ordered or a report of the refractive error and fundus findings, together with a report of the visual field findings (the latter by chart, if the field is abnormal) 12.50
0046—Examination by internist to determine diagnosis 15.00

OUTPATIENT TREATMENT BY SPECIALISTS

0047—Dermatological: first visit 5.00
0048—Dermatological: each subsequent visit 5.00
0049—Ear, nose and throat: first visit 5.00
0050—Ear, nose and throat: each subsequent visit 5.00
0051—Ophthalmological: first visit 10.00
0052—Ophthalmological: each subsequent visit 5.00
0053—Psychiatric treatment up to first half hour 5.00
0053A—Major portion of each additional half hour 5.00
0054—Neurological treatment up to first half hour 5.00
0054A—Major portion of each additional half hour 5.00
0055—Other comparable specialties not listed above: first visit 10.00
0056—Other comparable specialties not listed above: each subsequent visit 5.00

THE MEDICAL EXAMINATION IN SCHOOL HEALTH SERVICE

EDWIN R. VAN KLEEK, PH.D., *New York*

The Author. *Assistant State Commissioner of Education, New York State Education Department*

THE keystone of the school health service arch is the medical examination. Here, in most situations, more money is vital in getting an optimum program. But even here ingenuity can accomplish much at little cost. For example, parents, particularly those of kindergarten children and of children in the early elementary grades, can be invited and urged to be present during the medical examinations. Many of the parents will not come but the presence of those who do will cost the school nothing and can add greatly to the effectiveness of the follow-up for the correction of the remediable defects that are discovered. To obtain corrections the follow-up, not the examination itself, is of major importance. However, the medical examination should not be overlooked, for it does have some educational value *per se,* especially when done by a physician alert to the teaching opportunity present, and especially when the classroom teacher and the parent are present as observers.

There is grave danger in a scanty, superficial medical examination. If the examination is too hurried and brief, it may do more harm than good and it may even be worse than no examination at all. The parent who receives from the school a report indicating that no defects have been discovered may, quite understandably, assume that no defects exist. Actually, this type of examination may have overlooked several important defects, and the parent, knowing nothing of the quality of the examination, may be badly deceived. So may be the classroom teacher and sometimes even the principal, although the school nurse-teacher is not fooled for a minute. However, it is often quite impractical for her to say much or do anything in these situations for obvious reasons.

It would be a wonderful thing if the state and county medical societies and the medical profession as a whole disciplined that minority of practitioners who besmirch their great profession by this shabby type of examination. School people are not without some share of the guilt also, nor are boards of education when they know about such examinations and permit them to continue. Boards of education, which spend in states like Connecticut and New York from $200 to $400 per pupil per year, with an average in New York State of perhaps $300, not including capital outlay, are open to censure when they appropriate for the services of school physicians miserably inadequate sums. However, the fact that the salary is hopelessly inadequate does not excuse a physician for giving a correspondingly inadequate examination. Under those circumstances, he should do one of three things: (1) do a decent job for insufficient pay; (2) refuse the appointment; or (3) put the matter squarely up to the board of education and insist that the rate of pay per child be sufficient to permit a respectable examination, or at least that it should be at an hourly rate corresponding to that which the board has to pay bricklayers, for example. That rate, although inadequate for a doctor of medicine, would nevertheless be quite an improvement over what some school boards are actually paying.

This is something on which the county and state medical societies should act, not only for dignity of their profession but, even more importantly, in the interest of the health of children.

The practice in some communities of passing the job of school physician around from year to year among those of the local physicians who are interested is another less-than-optimum procedure, for the physician can do a better job if he has the assignment for several consecutive years. Agreement among the local physicians could often result in three- or four-year appointments rather than an annual change. This would not of itself add a penny to the cost.

Some classroom preparation of the pupils by the teacher or the nurse prior to the annual examination would cost nothing, nor would similar follow-up with the class as a whole after the examination involve any expenditure of funds. Such preparation and such follow-up are recommended when the children visit the dairy, the local bank, the museum, or make a trip to a historical site. Certainly the annual

Excerpt from address at opening session of Conference on Administrative Problems in School Health Education, Yale University, July 9, 1952

medical examination is more important than any of these!

It will cost nothing also to have the children strip for the examination. Even in schools lacking a nurse's office or examining room there will almost always be a principal's office, and it may be possible to use this in preference to a corner of the gymnasium.

The annual medical examination is or can be the keystone of the school health service program. A concept now prevails throughout our school system that a good, thorough medical examination every three years is better than a scanty, superficial one annually. Maybe it is, but what does that prove? A good square meal every day may be preferable to three scanty, superficial bites for breakfast, lunch and dinner—perhaps. However, it is not as good as three good meals a day! But what a fallacious comparison this one is! And yet, we hear this all the time. "Wouldn't you rather have the children given a thorough, unhurried medical examination every three years, in preference to these shabby, rushed, annual so-called examinations that are nothing more than flimsy inspections?" That's the type of nonsense we hear. How many people are satisfied to have their children examined every three years? In the "important" concerns of school and life, like ability to translate Caesar's Commentaries or to perform long division, infrequent examinations are not satisfactory. Examinations are given twice a year, or monthly or weekly. And yet here are human beings at the ages of most rapid physical growth and development, during the periods when changes are taking place at a faster rate than in any other decade of their lives, and arguments are heard that every three years is often enough for the medical examination! If the argument is based on money—the cost—another dollar or so per year per child to finance a better school medical examination could well be the most important and productive dollar spent by a board of education of all the $200 or $300 or even $400 it spends per year on each pupil. If health conditions are not appraised so that, where deficiencies susceptible of remedy can be found as the first step toward getting corrections done, there may well be a child on whom most of the other $200 per year is largely wasted because of his physical condition. This can be understood with relation to checking the crankcase oil in our automobiles. Most physicians and life insurance companies advocate annual medical examinations for adults, and all sorts of foundations come out full blast for additional special examinations to detect early evidences of tuberculosis, cancer, etc. And yet New York State recently had to refrain from distributing to its schools copies of a booklet on school health put out by the very highest of authorities in both health and education in this nation, because it was feared that it would encourage triennial rather than annual medical examinations. If one reads the relevant section carefully enough, one might see that it actually didn't advocate the triennial practice, but a really careful reading would be necessary to catch that.

Perhaps there are parts of the nation where a triennial examination would be an improvement over the present practice, and, in such cases, this pamphlet would doubtless be helpful. New York State, except the three largest cities of New York, Buffalo and Rochester, requires annual medical examinations of all school children. This applies to the parochial as well as to the public schools, and on application the parochial schools are entitled to the same health service supplied in the same community to the public school children.

In response to the quotation, "a good examination every three years is better than a poor one annually," the laws in certain areas outside New York State have been amended so that a triennial examination has been substituted for the annual one. In some of those cases, where the annual examination had been flimsy, the triennial one soon became equally so. Even if that does not develop, the philosophy of the late John Dewey, "try to get for all children what the wisest parent wants for his own child," should be applied to this issue.

Free Medical Care

At the end of August 1952 there were 97,836 patients under the roofs of Veterans Administration hospitals. Of this number over 63,000 were non service connected in their status and 800 were not even veterans at all.

On the same date there were 6,760 patients enrolled in non VA hospitals, about equally divided between service connected and non service connected.

This situation is almost identical with that existing just one year ago.

Offering -- nationally famous makes of

FURNITURE, EQUIPMENT and SUPPLIES including:-

W. D. Allison Company

Shampaine Company

Ritter Company

Welch-Allyn Company

Johnson & Johnson

Armour Laboratories

Raytheon Manufacturing Co.

Birtcher Corporation

J. Sklar Manufacturing Co.

Davol Rubber Company

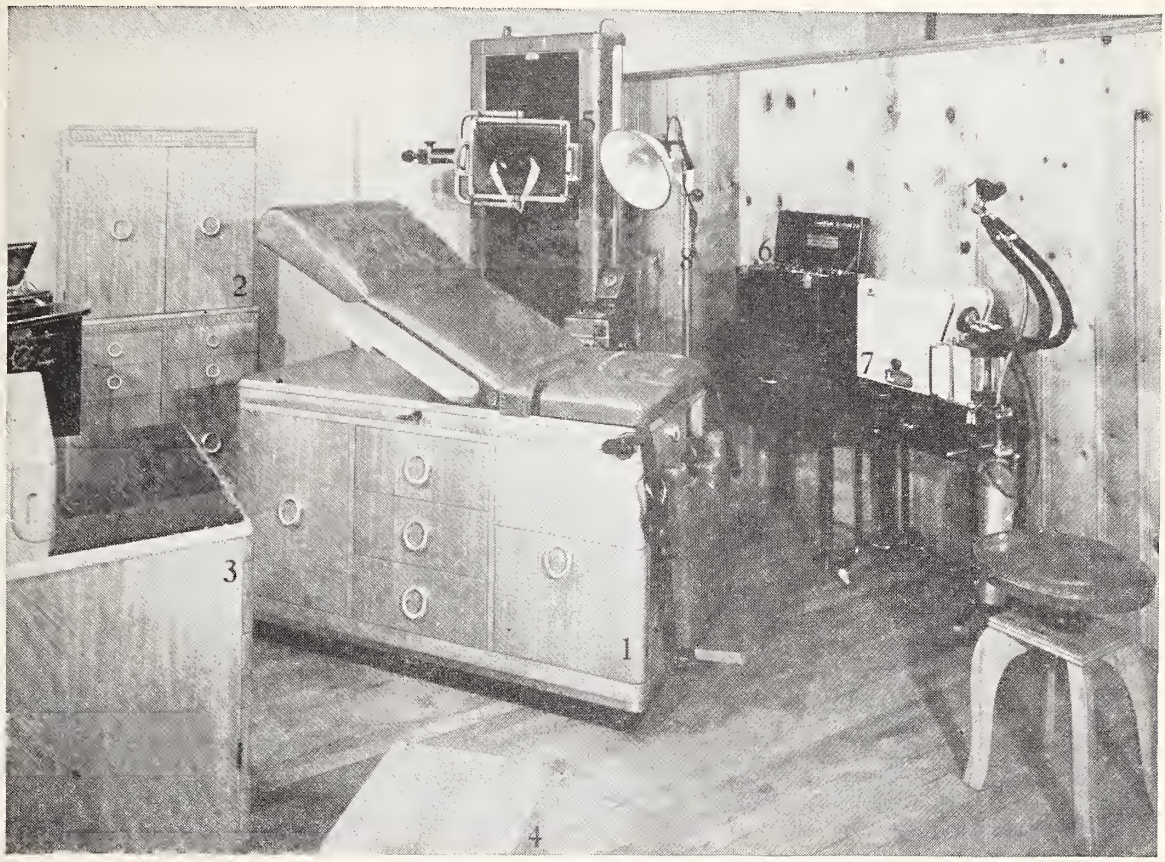
Seamless Rubber Company

Becton, Dickinson & Company

Americaine, Inc.

North American Philips Co.

and many others



One section of our large display room in Bridgeport

Telephone 5-3116 -- Enterprise 3190

American Surgical

SUPPLY and EQUIPMENT CO.

1715 BARNUM AVENUE P. O. BOX 150

BRIDGEPORT, CONNECTICUT

TODAY'S HEALTH

Published by the American Medical Association, *Today's Health* brings authentic health information to the home, school and public library.

More than two million people now find this health magazine in their physicians' offices and the number is increasing daily.

Today's Health is a modern, progressive medium of sound health information and should be available in *every* physician's office. Subscriptions are sponsored by the Woman's Auxiliary to the State Medical Society.

Connecticut State Medical Society
160 St. Ronan Street
New Haven 11, Connecticut

Please enter my subscription to *Today's Health* at the special physicians' rate of $3.25 for three years—or $1.50 for one year.

Check enclosed herewith ☐

Send bill with first issue ☐

Signed: .....

Office Address .....

.....

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette J. Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon
John O'L. Nolan, Hartford

Hartford County Physicians Answer 1,700 Emergency Calls in Six Months

Emergency medical call systems in Hartford, New Britain and Manchester received more than 1,700 calls during their first six months of operation, February 1 through July 31.

A report by Joseph L. Gordon, executive secretary of the Hartford County Medical Association, sponsoring organization for the plans, indicates that Hartford took leading place in providing this type of community service, with a total of 1,231 calls. The emergency system in New Britain received 493 calls during the period and in Manchester, where the system was in operation only five months, 28 calls were recorded.

Middlesex County to Publish Directory of Community Health Services

Members of the Middlesex County Medical Association voted at their recent semi-annual meeting to publish a directory of health services for residents in Middletown and adjacent communities.

The proposal was contained in a resolution presented by Dr. Harry C. Knight, chairman of the Association's Public Relations Committee, following a committee report on a survey to determine the need and degree of acceptance of such a directory.

Dr. Knight reported that community health organizations have expressed enthusiastic willingness to participate in the project. First publication of the directory, he said, will represent a pilot program of distributoin in test areas. Further distribution to all homes in the area will be based upon the results of these tests, he reported.

The Association voted to underwrite cost of the project, but it is anticipated other organizations may desire to share in its cost. The directory will include telephone listings of all physicians in the area and lists of voluntary and public health agencies and services. It is planned to design the publication so that it may be attached to the inside front cover of telephone directories.

AMA Continues Information Program

A recent announcement that the National Education Campaign of the American Medical Association has been officially terminated does not mean that the Association will discontinue its program of informing physicians and the people about important issues concerning health and medical care.

This was explained recently by Dr. Louis H. Bauer, AMA president, following announcement of the resignation of Dr. Elmer L. Henderson as chairman of the Campaign Coordinating Committee and resignation of Whitaker and Baxter, public relations concern that directed the campaign during the past four years.

The Association's Department of Public Relations has been expanded and will continue to furnish information on socialized medicine in addition to its many other functions. The termination of the Whitaker and Baxter phase of the educational program was in accordance with a resolution approved by the House of Delegates some time ago.

New Booklet for Medical Secretaries Being Used in Schools

More than 800 copies of the new AMA booklet, "Winning Ways With Patients," have been distributed for classroom use in secretarial and secondary schools throughout the State.

The distribution is in response to 40 requests received from secretarial course instructors following recent mailing of sample copies and information concerning use of the booklet as an educational aid. Continuing requests indicate the booklet will be in use by many more schools within the next month. Copies were recently mailed to physicians by the American Medical Association.

Information Service for New Residents in Hartford County

The Board of Directors of the Hartford County Medical Association recently approved a plan to inform new residents about emergency medical services and how they may engage the services of a family physician.

Approximately 200 new families move into the Greater Hartford area every month. Letters outlining the Association's services and activities will be sent to these families as soon as mailing lists can be obtained.

Medical Society Exhibit at Eastern States Exposition

The Council of New England State Medical Societies sponsored an exhibit on fraudulent devices and cures during the Eastern States Exposition in Springfield, September 14-21.

The exhibit was furnished by the American Medical Association, in charge of George B. Larson, assistant director of the Association's Bureau of Exhibits. Personnel from the State Medical Societies in New England worked with Mr. Larson during the exposition to relate the story of mechanical frauds and the exposure and conviction of their promoters. Attendance in the Industrial Arts Building where the exhibit was displayed approximated 50,000 persons daily.

Hall-Brooke Enlarges Facilities

Hall-Brooke, a loyal supporter of the JOURNAL, announces with satisfaction that after careful planning, facilities now have been made available for the specialized treatment of cases of alcohol addiction. A new unit—entirely separated from quarters assigned to "mental" patients—has been established for the use of alcoholics, under the personal supervision of Dr. Francis P. A. Williams, widely known for his work with this group at Easy Acres in Newtown, Connecticut. Patients in this new unit at Hall-Brooke will benefit from many modern aids in treatment brought to bear on their problem; expanded laboratory facilities, dynamically oriented psychotherapy (Diplomate, American Board), and 24 hour a day medical and nursing coverage. Additional aids include the resources of an enlarged occupational and recreational therapy department with registered therapists in attendance, as well as various athletic activities in Hall-Brooke's 120 acre estate.

This new unit will in no way supplant nor conflict with Hall-Brooke's half century of traditional service to patients suffering from conventional types of psychiatric disorders; a service that continues to grow with mounting success. Alcoholic patients are housed in their own separate, cheerful and clublike quarters with their own specially selected attendants. Cordial and reciprocal relationships are maintained with members of Alcoholics Anonymous, as well as with referring physicians and patients' families.

THE DOCTOR'S OFFICE

Irving S. Alderman, M.D. announces the opening of an office for the practice of physical medicine and rehabilitation at the medical building, 219 West Main Street, Meriden.

Eugene E. Cliffton, M.D. announces the opening of an office for the practice of surgery at 121 East 60th Street, New York.

Lewis P. James, M.D. and Maximilian A. Crispin, M.D. announce their association in the practice of gynecology and obstetrics at 350 Farmington Avenue, Hartford.

Walter F. Jennings, M.D. announces the opening of an office for the practice of orthopedic surgery at 50 Farmington Avenue, Hartford.

Vincent J. Longo, M.D. announces the opening of an office for the practice of diseases of the urinary system at 179 Montauk Avenue, New London.

Nicholas A. Marzialo, M.D. announces the opening of an office for the general practice of medicine at 474 Main Street, Manchester.

Joseph T. Noya, M.D. announces the opening of an office for the practice of pediatrics at 14 West Avenue, Norwalk.

George A. Rubin, M.D. announces the opening of an office for the practice of dermatology at 5 North Main Street, Meriden.

Theodore W. Steege, M.D. announces that he has resumed the practice of internal medicine and cardiology at 85 Jefferson Street, Hartford.

Dr. Andrew Jackson Spearheads Industrial Symposium

Acting under the auspices of the Industrial Health Committee of the State Medical Society and sponsored by the American Brass Company in Waterbury, Andrew Jackson put across a successful afternoon program at St. Mary's Hospital, Waterbury, dealing with disabilities of the back, shoulder, hand and knee as they occur in industry. Dr. Bosworth, orthopedic surgeon from New York City discussed back injuries. Dr. DePalma from Philadelphia, shoulder injuries, Dr. Littler from New York City, head injuries, and Dr. Della Pietro of Waterbury, knee injuries.

About fifty, including members of the Industrial Health Committee, speakers and invited guests, gathered at the Waterbury Country Club following the scientific session and enjoyed an informal exchange of ideas and opinions, climaxed by a delicious dinner. Dr. Bosworth of New York Polyclinic Medical School and Hospital provided the humor which is the prerequisite of a good toastmaster. Mr. Quigley, chairman of the Board of Directors of the American Brass Company, welcomed the guests and outlined the manufacturing program of his company. For over an hour those present listened to a psychiatrist, Maurice Frocht of New York City, reveal the size to which the problem of malingering among employees has grown and appeal to industry to employ psychiatrists, psychologist, and psychiatric social workers, even at the expense of the taxpayer, to stem the rising tide.

Dr. Jackson received a round of applause for his efforts over the past twenty years as medical director at the American Brass plant in Waterbury in improving health conditions among the employees and stimulating the interest of industry in the improvement of the health of the industrial worker.

No One Wishes to Bathe in Perfume?

So far as we have learned, no physician and wife doctor have applied for the position as professional attendants to a royal household where water is so scarce that the ladies bathe in perfume. Such an advertisement appeared in the *Journal A. M. A.* of September 6 entitled, "Physician to Royalty."

Plasma Fractions

The awareness of the need for blood, which has been caused by the publicity of the Red Cross Blood Program, has developed in the minds of the general public increasing interest in the use of blood and in blood fractions. "What do you do with blood that is outdated?" is a frequent question. Although the Blood Program may not as yet have developed as complete a utilization of blood as is attributed to the proverbial hog in a Chicago packing house, yet it can be safely said that through conversion of blood not suitable for whole blood transfusion to plasma or plasma fractions, the loss in the program is negligible.

Lay persons are very apt to ask how much plasma or plasma fractions can be procured from a pint of blood. The following table shows the approximate relationship between the amount of original blood and the quantity of useful products obtained through the Connecticut Regional Blood Program.

10 × 500 cc. whole blood = 2,000 cc. plasma
2,000 cc. plasma = 2 × 25 Gms. serum albumin
or 12 × 5 ml. vials gamma globulin
or 3 to 4 Gms. fibrin

The procurement of an adequate quantity of whole blood to meet the civilian needs of Connecticut remains the primary objective of the Connecticut Regional Blood Program. The problem of any occasional excess is being met by conversion to blood plasma or plasma fractions.

Medical Civil Defense

The Council on National Emergency Medical Service of the AMA has, during the past year, sponsored a series of articles on the medical aspects of civil defense. These have appeared in the *Journal A. M. A.* and are now reproduced in booklet form. available at 25 cents a single copy, 20 cents per copy for orders of 100 or more.

NEWS FROM WASHINGTON

Management Paying $1.5 Billion Annually for Life-Health Insurance Benefits

American employers are paying close to a billion and a half dollars a year for employee health and life insurance benefits. This is one of the findings of a U. S. Chamber of Commerce survey of "fringe benefits," or labor costs not shown on the actual payroll.

The survey, taking in 736 companies, is the third annual study by the Chamber in this field. It groups together "life insurance premiums, death benefits, sickness, accident and medical care insurance premiums, hospitalization insurance, etc.," and establishes that they cost management an amount equal to 1.4 per cent of its total payroll. (Because many companies purchase combined life-health insurance, no breakdown between the two is possible.)

An indication of the rapid increase in employer financed life-health insurance in the last four years is the fact that the average company now pays exactly as much for these particular items as for Old Age and Survivors Insurance (U. S. Social Security).

In addition to death and health insurance, fringe benefits include such things as pensions, workmen's compensation costs, terminal pay, profit-sharing plans and payment for time not worked (holidays, lunch hours, etc.). Their total cost to management, the Chamber found, equalled 18.7 per cent of payroll. In dollars, the Chamber estimates that American industry annually pays something less than 25 billion for these benefits. The report is available at U. S. Chamber of Commerce, Washington, D. C., at $1 per single copy, or 50 cents each for 50 or more.

Permanent "Rusk Committee" Proposed

The Health Resources Advisory Committee (Rusk Committee) has recommended that it (or a similar group) be continued on a permanent basis. Its summary report says: "It has become increasingly apparent . . . that some mechanism similar to the Committee should be continued not only during this period of mobilization but as a permanent statute of the federal government. The Committee believes it is vital that . . . at a sufficiently high organizational level to make its work effective, there must be a coordinating body in the health fields if full utilization for both civilian and military needs is to be made of the health potentials of our nation."

The Committee, organized in 1950, now has three roles, (a) advising Office of Defense Mobilization on all health matters, (b) functioning as the National Advisory Committee to Selective Service, and (c) advising Defense Department on call up of medical reserves by balancing civilian against military needs for physicians and other personnel in the health fields.

The Committee commended the Armed Services for providing the best military medical care in history, while at the same time reducing the physician ratio from the World War II peak of six per 1,000 troops to the current 3.7. This means, the Committee explains, that 5,000 physicians who might be in military service have remained in civilian practice. The Defense Department saving resulting from the lower ratio was estimated at 40-50 million dollars.

Civil Defense to Step Up Blood Program Sharply, Spending Nearly $34 Million

After long delay, Federal Civil Defense Administration has decided on its blood plasma requirements for the fiscal year ending next June 30. Its goal is a reserve of 1,379,000 plasma units (179,000 on hand in September), production of which will require 3 million pints of whole blood. The last blood collecting campaign, the well advertised Armed Forces Blood Program, produced 2.9 million pints in 11 months.

CDA expects eventually to have a reserve of 7.5 million units, divided equally between plasma and blood expanders. This total conceivably could be reached in 1954, providing there are no unforseen demands on the nation's supply of blood and the projected rate of collecting and processing for the next nine months can be maintained into the following year. As of September 15, CDA had 1.5 million units of expanders, in addition to its small supply of plasma.

To finance its efforts between now and June 30, CDA has $18,750,000 left over from last year and $15,000,000 Congress appropriated this year for medical stockpiling. Collecting and processing of donated blood will be directed by the National Blood Program, in which all affected associations and government agencies are cooperating. CDA will pay collecting and processing costs for the amount it receives.

Formula Revised for Hill-Burton Fund Distribution

Because of population and income changes, the state-by-state formula for distribution of federal hospital construction funds (Hill-Burton) has been revised. The new schedule becomes effective July 1, 1953 and will continue through June of 1955. Under the program, the various states' shares of money voted by Congress are determined by per capita income, population and the need for new hospital facilities, with emphasis on rural areas. The formula sets for each state a specific percentage, representing the portion the federal government is prepared to contribute toward total hospital construction costs. The dollar amounts cannot be determined until Congress has voted appropriations for the two years involved. For the current year, $75 million is available for new commitments, a reduction of $7.2 million from the previous fiscal year. Under the new schedule, North Dakota receives the largest percentage increase, 9 per cent. Montana and Oregon are upped 4 per cent each, and California, Colorado and Idaho 3 per cent each. The largest decrease, 5 per cent, is charged against Delaware. The Hill-Burton program is managed at the federal level by the Division of Hospital Facilities, which operates under U. S. Public Health Service in Federal Security Agency.

Gamma Ray Generator, First of Type, Developed by Navy

Naval Medical Research Institute in Bethesda, Maryland, recently disclosed that its atomic medical division has developed and is now operating a gamma ray generator which gives reproducible uniform total body irradiation. Its source material is Cobalt-60, obtained from Oak Ridge laboratories of Atomic Energy Commission. Preliminary work on the generator was begun at Bethesda in 1949. Navy says it is first apparatus of its kind built anywhere.

Another Navy "first" is its new scientific exhibit, "Radioisotopes in Medicine," shown for first time in September at annual scientific assembly of D. C. Medical Society. Display is composed of four parts: Evaluation of blood substitutes; use of radioactive colloidal gold in complications of malignancy; a method of localizing intracranial neoplasms, and Iodine-131 treatment of thyroid cancer.

FTC Asks Court to Enjoin "Diet Supplement" Claims

In an unusual action, Federal Trade Commission has gone to court—as a public health protection measure—for an injunction that would curb advertising claims in behalf of a commercial product that is being marketed as a "diet supplement." The proprietary is called NHA Complex, sells for $5 per 11 ounce can and is put out by National Health Aids, Inc., of Baltimore. Very rarely does FTC request court intervention in cases of this kind. The step has been taken in this instance because Commission feels serious damage can be done to purchasers' health, as well as their pocketbooks, if allegedly false claims for NHA Complex are not curbed pending final disposition of FTC proceedings instituted months ago. Case is before U. S. District Court for Maryland.

FTC says product's annual sales are in excess of $600,000 a year, mainly on strength of television and radio advertising that leads listeners to believe NHA Complex is good for arthritis, lumbago, coronary thrombosis, bad teeth, gall stones, etc. Affidavits were obtained from two Baltimore and two Washington physicians to effect that this vitamin compound is of no value in treating any of these conditions. FTC also produced sworn statements by two psychologists who said that the nationally broadcast and telecast programs were cleverly composed and presented to sell public on thesis that many diseases stem from dietary deficiencies and that's where NHA Complex comes in as a protective weapon.

If this type of advertising is not halted, according to FTC's petition, the result may be "irreparable injury to the public in that persons induced by such false advertisements to purchase said preparation may delay proper diagnosis and treatment, or may suspend proper treatment of various diseases and symptoms for which NHA Complex, taken as directed, is of no value."

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Classification of Priority III M.D.'s Moving Terrifyingly Fast

Monthly report by Selective Service headquarters on status of special registrants under doctor-draft law reveals some interesting figures. Granted that these regular compilations are not distinguished for their accuracy and that current one, dated August 31, already is out of date, it still points up a trend or two. Perhaps most noteworthy is sharp increase, compared with July 31 report, in classification of Priority III physicians and dentists. At end of July, only 2,038 out of a total of 32,636 medical III's had been classified by local draft board; a month later, the figure had risen to 16,890, out of a total of 32,748. Correspondingly, for dentists, the figures have jumped from 1,899 out of 14,724 in July to 9,329 out of 14,732 as of August 31. Thousands more have been classified in September but armed services will not call upon Selective Service to supply any Priority III physicians before late spring, 1953.

Physical Examinations Lag

Although draft board classifications are moving swiftly, physical examinations of III's—both physicians and dentists—is going slowly. As of August 31, there were 13,864 physicians and 7,534 dentists in 1-A who were still awaiting physicals. For that matter, 892 physicians in Priorities I and II had not yet been examined though they were in 1-A. Also 266 dentists in this same category. But the most reassuring information to physicians in III who fear they will be in uniform soon because they have heard from their draft boards is this—before they can be called up, the military must bring on active duty 2,431 I's and II's who hold Reserve commissions.

17,000 Once-Deferred 4F's Now in Service

The lowered mental standard for military induction, ordered by Congress, is bringing results. Already 17,000 men once classified IV-F for mental reasons are in uniform and approximately the same number are awaiting induction. Of the 114,000 reexamined so far, 33,000 or slightly less than one-third have been found mentally fit for service. Still to be reexamined are 186,000. Congress in June, 1951, directed that the percentile score in the Armed Forces Qualification Test (mental) be lowered from 13 to 10. Reexaminations began the first of this year and are now running at the rate of about 25,000 a month. Congress also ordered that the same physical standards effective in 1945, at the close of World War II, should prevail. The armed forces say, however, that since 1948 physical standards have been no higher than in 1945.

Registration of Hospital Residents and Interns

Selective Service's National Advisory Committee is appealing to hospital administrators for help in urging recently graduated physicians to register under the doctor-draft law. "The only exception," the notice says, "is for those who must complete their internship before receiving their degree and during such internship apply for and accept a commission in the armed forces."

Urge Doctors to Take More Interest

The AMA Board of Trustees has reiterated its previous stand that doctors everywhere should take a more active interest in the affairs of the American Legion. Physicians who are members of the Legion were urged specifically to attend meetings of their posts since the policies of the Legion, like those of the AMA are decided at the grass roots level.

The Board's expression came after it had studied a report on health matters which were discussed at the Legion convention in New York a short time ago.

Legion delegates adopted a resolution opposing I.L.O. procedures that would socialize medicine by international treaty, and they turned down another resolution which would have mandated the Legion

to urge the Veterans Administration to give special recognition to chiropractors. This would have permitted veterans to choose chiropractic treatment at government expense. A similar resolution for optometry was also defeated. The chiropractor resolution, coming from eight state departments of the Legion, resulted in one of the bitterest battles on the floor of the convention. The fact that it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.

(Local posts will have to show a considerable change of heart in their interest in altruistic medical projects before many physicians will find it worth their while even to attend post meetings, let alone take any active part in implementing Legion policies. Nationally the Legion may have the interests of the physicians at heart, but there is still a lot of rah-rah stuff and political shenanying in many state and local Legion organizations.—Ed.)

LETTERS TO THE EDITOR

End Results of Uterine Cancer Therapy

In May, 1913 I attended a meeting of the German Gynecological Society in Halle and listened to reports on radiation therapy of cancer of the uterus. I heard Ernst Wertheim says, "All my life I have labored to perfect the extended operation for removal of the cancerous uterus. I now see that radiation therapy is the treatment of the future. This is indeed a sad day for me." His prophecy was correct at least until recent years.

During the past decade, however, surgical treatment of cancer of the cervix has been taken up anew, for blood replacement and modern anesthesia have removed most of the limitations of what the human body could withstand, which had defeated the earlier surgeons. We are at last beginning to have for study the five year results of these newer methods. Though there are other advantages or drawbacks to either method, as the case may be, the commonly accepted measure of effectiveness of most cancer therapy is "how many are alive without evidence of disease at the end of five years?" It is becoming clear that a definite answer cannot yet be given as to the superiority of either plan of treatment, even in the early cases.

This is perhaps the most fascinating information to be found in the 7th Annual Report of Radiotherapy in Carcinoma of the Uterine Cervix just received from Stockholm. (Edited by J. Heyman with M. Donaldson and J. V. Meigs.) This report summarizes records of 65 institutions in 14 different countries, 21 of which are in Canada and the United States. The records are carefully compiled under uniform methods and furnish information on 70,178 patients examined, of whom 93.2 per cent were treated.

The "overall relative apparent recovery rate," i.e., alive 5 years after treatment without evidence of disease, was 32.6 per cent. The corresponding rate in the 2nd Annual Report was 26.3 per cent. In nine institutions which examined 6,579 patients, 1941-1945, inclusive, the rate was 41.4 per cent even including those who were examined but not treated. This is indeed progress.

Gynecologists are interested particularly in recovery rates according to the stage of the disease at onset of treatment. The five year relative apparent recovery rates for the whole study were as follows: Stage I 58.7 per cent, Stage II 40.0 per cent, Stage III 21 per cent, Stage IV 6.3 per cent.

In an attempt to estimate the relative rates in operative cases and those treated by radiotherapy only, tables were constructed for Stage I cases treated during 1941-1945, inclusive, at institutions where hysterectomy is practiced to a reasonable degree, and for institutions where radiotherapy is the method of choice. It is pointed out that "a direct comparison of the relative recovery rates in the operative cases and those treated by radiotherapy only is not justifiable because the two series would refer to material selected in different ways."

One table included "all collaborating institutions which report on at least 50 Stage I cases treated in 1941-1945, inclusive, and where at least 10 per cent were operative cases" (1,708 cases). The second table was similar, each institution reporting at least 50 cases, none of which were operative. The five year apparent recovery rate for the operative case group was 60.1 per cent. The radiotherapy cases showed 64.4 per cent. It is interesting to note that the similar rate for five United States clinics with 425 cases was 66.5 per cent for operative cases, while

three United States clinics which used radiotherapy only had a rate of 68.0 per cent. It can be said, therefore, that the case for radical surgery is not yet proven on the basis of five year results.

These annual reports are becoming increasingly significant as measures against which our own results may be placed. We cannot long be content to do less well by our patients than is done elsewhere. We must at least arrange our end result studies in such a manner that comparisons can be made with the foremost clinics of the world. Their records are being published where everyone who wishes may read.

James R. Miller, M.D.

Resign AMA Position

September 22, 1952

To the Editor:

Whitaker & Baxter are signing off today as AMA representatives, to accept a new assignment.

This farewell bulletin is mainly to say how much we value the happy associations of the past four years; we both think the doctors of America are pretty wonderful people. We also believe the whole country is better because the members of the medical profession and their lay representatives have proved themselves dedicated citizens in the cause of American freedom.

The past four years, even though they have been crowded years for all of us, have been very satisfying years to Whitaker & Baxter and we hope that you, too, have found deep satisfaction in the fight we have made together. We feel sure you have great pride in the public respect and public support which medicine has won—and in signing off, we want to say we are proud to have been your representatives.

With every good wish, we are

Sincerely,
Clem Whitaker
Leone Baxter

Hartford Hospital Medical Library — 19th Century

To the Editor:

If any of your readers know anything about "The Hartford Hospital Medical Library" during the nineteenth century, will they please communicate with Dr. Arthur S. Brackett, Bristol, Connecticut? Telephone 3735.

American Heart Association, Inc.

The Protection of Rheumatic Fever Patients Cared For on the Wards of General and Children's Hospitals

Because questions frequently arise in connection with the protection of rheumatic fever patients in general and children's hospitals, the following statements intended to guide such hospitals are issued by the Council on Rheumatic Fever and Congenital Heart Disease of the American Heart Association. They should be regarded as embodying certain principles which an individual hospital may apply in its effort to achieve protective measures.

1. Attacks of rheumatic fever frequently follow group A streptococcal infections—usually of the upper respiratory tract.

2. Persons who have recovered from an attack of rheumatic fever or who have rheumatic heart disease, even though the rheumatic fever may be quiescent, are especially liable to develop a recurrence of the disease if they contract a Group A streptococcal infection. Moreover, a new rheumatic attack may be induced in a patient in the subacute active stage if he contracts a new infection with Group A hemolytic streptococci of a serological type, or types, different from that which previously infected him.

3. The introduction of rheumatic fever patients into hospital wards or other environments, such as Out-Patient Departments, where Group A streptococcal carriers may be encountered, exposes them to hazards which should be avoided. To the extent that is reasonably possible in the individual institution, protection of such patients from contact with other patients, visitors or employees suffering from such hazardous infections should be practiced.

Patients suffering from scarlet fever, erysipelas, or acute glomerular nephritis may be considered specially dangerous even without further laboratory confirmation of type of organism involved. Sore throat or acute tonsillitis, especially when associated with exudates, distinct fever, and leucocytoses, may ordinarily be considered almost as dangerous. Milder upper respiratory infections are also dangerous. Dust and lint from bedding, handkerchiefs, and clothing

The term "Rheumatic Fever" is considered to include rheumatic fever and rheumatic heart disease, for the purpose of this statement.

n the immediate environment of a person who is expelling streptococci from his mouth or nose are potent sources of infection, as are also dishes and other utensils he uses.

4. Susceptible rheumatic fever patients while in dangerous environments such as open wards should receive treatment (chemotherapeutic or antibiotic drugs) that will markedly decrease their liability to contact such streptococcal infections. Furthermore, it is possible by suitable protective measures to render their environments comparatively free from danger of reinfecting them with Group A hemolytic streptococci. For suggested appropriate individual treatment see Section below.

5. To the fullest extent possible within the laboratory facilities of the hospital, or those available to the hospital, all reasonable efforts should be made to determine the presence of Group A streptococci among patients or personnel of the ward and to deal appropriately with such cases when the organism is identified.

6. Mindful of the above facts and recognizing that in the average general hospital environment complete communicable disease ward precautions and techniques for the protection of the rheumatic fever patient are neither possible nor psychologically desirable, the hospital caring for such patients should nevertheless institute procedures and measures which will protect such patients. Detailed protective procedures should be developed by the individual institution through the collaboration of the appropriate responsible members of the medical, pediatric and laboratory staffs, Nursing Department and Administration.*

In developing protective measures which will in effect better protect the rheumatic fever patient from his environment and not others from him, strong emphasis should be placed on appropriate education of the patient, the family and hospital workers who are in regular or casual contact with rheumatic fever patients.

APPROPRIATE INDIVIDUAL TREATMENT (CHEMOTHERAPEUTIC OR ANTIBIOTIC DRUGS)

The following outline of appropriate treatment of the patient and streptococcal carriers in his environment may be considered adequate:

1. Protecting the patient against streptococcal infections by:

(a) Daily oral administration of small doses (0.5 to 1.0 Gm.) of relatively non toxic sulfonamides, or

(b) Daily oral administration of 200,000 units of buffered penicillin G divided into two doses and given on an empty stomach. Other antibiotics may have a similar prophylactic influence and may be employed, but more experience is available with penicillin.

2. Reducing the danger arising from other patients with streptococcal infections or from carriers of Group A hemolytic streptococci.

(a) This can be effected by giving large doses of penicillin, or other antibiotics for a period of ten days to those patients who are expelling streptococci. Such attempted elimination or diminution of the carrier state with respect to hemolytic streptococci should be bacteriologically controlled if possible.

(b) Patients who have been in contact with a known case of streptococcal infection should be treated in the same way as those with streptococcal infections.

3. Attempting to cure streptococcal infections in a rheumatic fever subject early in the course of such an infection by intensive antibiotic therapy, started promptly and continued for 10 to 14 days.

Prophylaxis of the rheumatic attack is probably most effectively attained by intramuscular administration of an antibiotic drug. It can also often be effected by oral administration of one million units of buffered penicillin G daily, divided into four equal doses given on an empty stomach. Rheumatic fever patients so treated should be carefully studied both clinically, and by suitable laboratory and electrocardiographic techniques, to ascertain whether rheumatic sequelae have been really prevented or only reduced to a sub-clinical level.

*Those seeking detailed communicable disease protective procedures from which to pattern specific procedures may well refer to "The Control of Communicable Disease in Man," American Public Health Association, Seventh Edition, 1950, and "Guide for the Handling of Communicable Diseases in Hospitals," New York State Department of Health, 1950.

FROM OUR EXCHANGES

"Medicine on the March" is an interesting discussion of the doctor-patient relationship by the president of the California Medical Association, H. Gordon MacLean *(California Medicine,* 76.5). Dr. MacLean skirts around the topic that science is amoral. "Neither the patient nor the doctor is a robot," and in "these days of scientific invention . . . patients feel the need of the art of medicine and of a closer doctor relationship more than ever." The patient needs as never before "a doctor who will not only work modern scientific miracles but be an adviser, a listener and a friend."

The need of the day in obtaining good doctor-patient relationship is the supplying of first class medical care at a price within the ability of the patient to pay. Doctors of medicine "have always given their services to those unable to pay for medical care and always will." There is praise for all prepayment insurance plans but it is recognized that they do not as yet do a full job. Every man needs a personal physician who is interested in the whole man.

Humanism has lagged behind science but only because of recent unbelievable scientific progress. Dr. MacLean is of the opinion that the age of humanism will return, for it is in the history of medicine an older quality of the mind and heart than in the other sciences. What we need to add to our scientific training is "man's friendship for man."

* * * *

The treatment and management of lung abscess is the subject of discussion in two articles in *California Medicine* (76.5). William L. Hewitt points out that the fusospirochetal group of bacteria are the commonest etiological agents in abscess of the lung. The first choice of drugs is crystalline penicillin in the majority of cases. In a small number of cases streptomycin is indicated where the Klebsiella is the clinical etiological agent. Aureomycin, chloramphenicol and terramycin may produce an excellent therapeutic response, either initially or after therapeutic failure with penicillin. Administration of the antibiotic by inhalation should be carried out in conjunction with systemic forms of treatment.

Francis X. Byron doubts the advisability of surgical drainage of lung abscess. The mortality rate and other hazards of surgical drainage must be re-examined in the light of treatment with the newer drugs. The use of penicillin, bronchoscopic treatment and postural drainage results in the cure of 80 per cent of cases with acute abscess and in a smaller per cent of cases with chronic abscess. It is not to be forgotten that there is a better chance for diagnosis and for effective resection of associated carcinoma when conservative treatment is employed.

* * * *

Walter M. Kirkendall ("Recent Developments in Therapy for Essential Hypertension," *Jour. of Iowa State Med. Soc.,* 42.5) notes that the low salt diet regime often represents the only effective agent in the treatment of some cases of benign hypertension and that it may be the only available treatment of malignant hypertension with uremia. It is Dr. Kirkendall's current policy to consider and to recommend sympathectomy on individuals who are young, who do poorly on available medical regimes or combinations of them and on early, young malignant hypertensives with good renal function.

The use of bacterial pyrogens for the treatment of malignant hypertension has resulted frequently in a clear reversal of the process. The treatment is empiric for there is no valid explanation for the favorable results. The beneficial results of treatment with pyrogens may be due to the fever which temporarily increases the renal blood flow.

It should be remembered that treatment with pyrogen is extremely vigorous and unpleasant and that it only should be considered in a disease as serious as malignant hypertension. The treatment is lengthy and the patient will frequently complain bitterly of the discomfort and inconvenience associated with it. By splitting the dose of Pyromen and gradually increasing the daily dose Kirkendall has apparently minimized the discomfort and still produced the desired amount of fever. In conclusion it seems to Kirkendall that it is probable that the malignant phase of hypertension may be reversed by pyrogens. The pyrogen appear to have little value in the earlier stages of the disease. Exact indications

for their use have not been finally evolved but the chances of benefit appear to be greater in those patients with fair renal function and in the younger age group.

* * * *

Herbert Conway in "Cancer of the Head and Neck" (*Jour. of Mich. State Med. Soc.*, 51.4) states that the aims of the treatment of head and neck cancer are, in the order of their importance, the cure of the tumor, the correction of the defect resultant from the radical excision, and the return of the patient to a useful economic and social life at the earliest possible date. Combined excision and reconstruction is feasible and practical in a high percentage of cancers of the head and neck.

* * * *

Cancer of the scrotum is almost always associated with environmental factors, according to Hazen L. Miller (*Jour. of Mich. State Med. Soc.*, 51.4). Almost without exception this form of cancer is found in men who are exposed to tar, pitch, lubricating oils, crude wool or other carcinogenic agents. The tumor is usually a squamous cell carcinoma, grade II, and may be diagnosed early and effectively by a biopsy that includes the margin of the lesion. Unfortunately an early diagnosis is rarely made. The warty growth appearing on the most dependant part of the scrotum is "treated" by the patient himself. On the average the first medical visit is one or more years after the lesion appears.

Cancer of the scrotum is preventable. Education is the ideal method of approach. The prognosis in late lesions is poor. The average duration of life is twenty-one months after the onset of symptoms. Deaths from cancer of the scrotum should be a genuine rarity.

* * * *

W. D. Gatch in opening a "Symposium on Fluid and Electrolyte Balance" (*Jour. of Indiana State Med. Soc.*, 45.5) makes the observation that "we give too many intravenous injections. After operation, early alimentation is more important than early ambulation."

* * * *

Weil's disease in the opinion of Cowden et al (*Amer. Pract.*, 3.5) is a diagnosis that is made less frequently than would be expected from the incidence of the disease in the United States. The laboratory diagnosis has depended on demonstration of leptospira in the blood and urine, on animal inoculations and specific agglutination reactions. All these procedures are difficult and often unsatisfactory.

A biopsy of striated muscles seems to have diagnostic value. There is a positive finding focal involvement of isolated muscle fibers or small groups of fibers. The earliest changes are vacuolization, loss of cellular detail and striation followed by sarcolemmal proliferation. A second feature of importance in diagnosis seems to be the demonstration of xanthochromic spinal fluid. The combination of jaundice and xanthochromic spinal fluid is rare in other conditions.

Penicillin apparently does not alter the course of the disease. Aureomycin sometimes, and perhaps often, has a favorable result in the treatment of Weil's disease.

* * * *

One of our new exchanges, *Estudios Sobre Esterilidad*, the official publication of the Mexican Association for the Study of Sterility, carries as its leading article in a recent issue (3.2), La Falta de Orgasmo como causa de Esterilidad by Colineiro-Laforet. The author arrives at these conclusions:

(1) In women of normal fertility, organsm is not necessary for conception, but makes it easier.

(2) In women of deficient fertility, whether or not there be objective proofs, the lack of orgasm is a cause of sterility.

(3) Any systematic exploration of sterility must be considered incomplete while the sexual behaviour of the patient and the existence or lack of orgasm in intercourse is not investigated.

Blythewood Sanitarium Expands

Blythewood Sanitarium in Greenwich has recently expanded its facilities to accommodate convalescents and cases of general invalidism. The sanitarium is situated on a thirty-eight acre landscaped tract. All rooms and cottages have been redecorated. The consulting staff consists of the chiefs of the various departments of the Greenwich Hospital. Rates are from $85 per week, semi private, to $100-$150 per week with private rooms. Tuberculous patients are not accepted.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
First Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville

Report on the School of Instruction for all State and County Officers and Chairmen

The Woman's Auxiliary to the Connecticut State Medical Society held its annual school of instruction for all State and county officers and chairmen on Tuesday, September 9, in the Church of the Redeemer auditorium, located on Cold Spring Street, at Whitney Avenue, in New Haven. Following the registration at 10:30 A. M., Mrs. Barnett Freedman, State president, opened the meeting. The minutes were read by Mrs. Edward F. Malloy of Stamford. A new set of resolutions, adopted by the group and recently published in the September issue of the CONNECTICUT STATE MEDICAL JOURNAL, was read by Mrs. Edward T. Wakeman. Guest speakers on the program were Edward T. Whalen, president of the Connecticut State Medical Society and Thomas M. Feeney of Hartford. Dr. Whalen, in his welcoming speech, commended the group for the work which they are doing. Dr. Feeney presented a discussion and explanation of "The Keough-Reed Bill," introduced into the 82nd Congress, entailing a plan of security for physicians of retirement age.

The following chairmen conducted round table discussions: Mrs. Barnett Freedman, county residents, public relations and telephone; Mrs. Paul Vestal, editorial; Mrs. Dewey Katz, program; Mrs. William Shepard, legislation; Mrs. E. Roland Hill, civil defense; Mrs. Morton Arnold, membership; Mrs. Norman Barker, treasurers; Mrs. William Wener, finance; Mrs. Royal Meyers, *National Bulletin;* Mrs. Chris Neuswanger, nurse recruitment; Mrs. Creighton Barker, school health; Mrs. William E. Buckley, *Today's Health.* The purpose of these discussions was to acquaint each State officer with her duties and responsibilities for the year.

LEGISLATION

The Legislation committee reported that emphasis was placed on the importance of stressing to each county chairman that local voters lists be checked for medical families not registered.

MEMBERSHIP

Hartford and Windham County reported 100 per cent paid up membership.

NURSE RECRUITMENT

An intensive campaign to alleviate the current shortages of nurses is being planned. "Nurse Recruitment Week" will be held in New Haven about November 10. This program is being planned by the Visiting Nurses Association with the cooperation of the New Haven County Medical Auxiliary and many other local groups. The organization of future nurses clubs in the high schools, was also discussed in connection with this program.

TODAY'S HEALTH

In order to meet a quota of 1,100 points, each member of the Auxiliary is urged to be aware of subscribing or giving a gift subscription of *Today's Health* magazine.

New Haven County News

SEMI-ANNUAL MEETING

Plans are being made for a semi-annual meeting to be held on Tuesday, November 18, at the "Red Barn" in Westport.

Mr. Paul V. Hayden, director of public relations for the Connecticut Light and Power Co., will be guest speaker. Mr. Hayden will discuss the parallel that exists in the encroachment of the Federal Government in the utility field and the socialization of medicine.

NURSE RECRUITMENT

This year the New Haven County Medical Auxiliary are combining their program on nurse recruitment by cooperating with a recently formed community wide committee. Their plan is to launch an intensive campaign to alleviate the current shortages of nurses in the New Haven hospitals and the immediate area. The committee will center its efforts on nurse recruitment programs in the secondary schools.

It is the aim of this committee to present the educational advantages of present day nursing to vocational councilors, by bringing them up to date on entrance requirements, scholarship information, etc.

In order to correct much misinformation among adults as to the duties of nurses, the committee will endeavor to bring parents the up-to-date story on nursing, by stressing its satisfactions and security as a career.

The Nurse Recruitment "Open House" sponsored every year by the New Haven County Medical Auxiliary is scheduled to take place between November 10 and 15 under the chairmanship of Mrs. Joseph D'Esopo.

Members of the New Haven County Medical Auxiliary who are lending their support to this Nurse Recruitment Week Committee are: Mrs. Barnett Freedman, president, Connecticut Woman's Medical Auxiliary; Mrs. Orvan Hess, president, New Haven County Medical Auxiliary; Mrs. Joseph D'Esopo, Recruitment chairman, New Haven Haven Woman's Auxiliary; Mrs. Charles Culotta, secretary; Mrs. Emerson Stone, chairman, Speakers Bureau; Mrs. Paul Vestal, chairman, Public Relations, Grace-New Haven Auxiliary; Mrs. Raymond Zagriniski, headquarters volunteer.

A group of community organizations supporting the committee are being represented by the following: Mrs. Marion Fleck, director, Grace-New Haven School of Nursing; Miss Lillian B. Reilly, associate director of School of Nursing, St. Raphael's; Miss Dorothy Wilson, executive director, Visiting Nurse Association; Mrs. Max Schwartz, Visiting Nurse Association; Mr. Alfred H. Marshall, assistant director, Grace-New Haven Community Hospital; Miss Marion Redmond, director, Bureau of Nursing, Health Department; Mrs. Eva Goldstein, president, Connecticut State Nurses' Association; Dr. Samuel Spinner, secretary, New Haven County Medical Association; Dr. Arnold Rilance, secretary, New Haven Medical Association; Mrs. W. C. Moran, St. Raphael's Women's Auxiliary; Miss Sarah Wallace, head counselor, Sheridan Junior High School; Mrs. Grover Ducharme, chairman, Nurse Enrollment, American Red Cross; Miss Elaine Homer, chairman, Polio Recruitment, American Red Cross; Miss Esther Gilbert, executive director, Committee on Nurse Recruitment.

This program was recently endorsed by the New Haven County Medical Association and a committee of members who will represent the Association on the general campaign committee.

SCHOOL HEALTH COMMITTEE

At the first meeting of the School Health Committee it was decided to work for the establishment of advisory health councils in schools where such councils do not already exist. A brief questionnaire is being sent to all school principals. Also a letter is being sent to the State Parent Teachers Association to ascertain if every local organization has a health and safety chairman. This program was decided on after attending the conference on administrative problems in school health education sponsored by the Connecticut Health League conducted at the Yale School of Public Health in July. The key speaker, Edwin R. Van Kleek, PH.D., assistant State commissioner of education from New York, said "Every school can have its own health council comprised of the school physician at least in an advisory capacity, school nurse-teacher, principal, teachers of physical education, home economics, biology, general science, health, perhaps some pupils, certainly PTA members and the custodian." He went on to stress the importance of good medical examinations with class room preparation of the pupils by the teacher or nurse prior to the examination and a follow-up with the class as a whole afterward. Parents should be urged to be present at medical examinations of young children so that corrections of remediable defects can be brought to their attention.

TODAY'S HEALTH

Through the years, the House of Delegates of the American Medical Association has adopted various resolutions relating to the Woman's Auxiliary. In 1931, twenty-one years ago, the above body passed its first resolution. It concerned *Today's Health* (then *Hygeia*) and it "urged that the Woman's Auxiliary, to the American Medical Association, including county, state and national organizations, recognize as one of its chief objectives the promotion and distribution of this publication."

We, in Connecticut, have done a mediocre job in this one auxiliary endeavor. This has been due in some degree to a reluctance on the part of many physicians contacted to subscribe to this magazine; and to a greater degree, the fact that the promotion of this magazine has been left in the hands of just the *Today's Health* committee in each county.

Realizing the tremendous task and responsibility put upon these committees, it is the wish of your president that this year each member be part of the *Today's Health* promotional sales committee. If each member would give as a Christmas gift a subscription to either her child's teacher, her beautician, or as a baby gift to a new mother; or secure a subscription from a dentist or other professional person; our goal of 1,100 points could be easily attained or surpassed. Each year's subscription counts for one point.

We, as auxiliary members should be familiar with the magazine ourselves, if we are to be enthusiastic in its promotion. Are you a subscriber? Does your husband have it in his office? Won't you cooperate to make this a banner year?

A subscription form appears in this issue at a specially reduced rate. Use it today. Mail it to your county's *Today's Health* chairman. Now!

Health is our interest. It is good public relations to promote this, the authentic health magazine of the American Medical Association.

Lillian W. Freedman

AMA Still Fighting Compulsory Health Insurance

Mr. Truman told the press recently that from the newspaper accounts he read he had the impression that the AMA was giving up, and acceding to his demands for a national compulsory health insurance program. There was confusion in the way some of the stories were written; headlines, especially, gave some readers that impression. But, this was not true.

The President added to the misunderstanding when he said he thought his Philadelphia speech on medical care for the American people—the speech he delivered before the American Hospital Association—caused the AMA to disband its organization setup to fight his national health program.

Mr. Truman told his news conference he thought what finished the battle was a "certain speech" which he made in Philadelphia. He asserted the AMA officials admit now by their action that they have been wrong.

Dr. Bauer, president AMA, quickly issued a statement to the press, saying that Mr. Truman had some mistaken ideas about the AMA's giving up.

"The American Medical Association will never cease its fight against national compulsory health insurance," Dr. Bauer's statement said, adding: "Mr. Truman's Philadelphia speech had no bearing whatsoever on the decision to disband a special committee set up to conduct an intensive short-term, educational program against socialized medicine. This decision was reached by the AMA House of Delegates last June, and was widely publicized at the time.

"The National Education Campaign was merely one intensive phase in the medical profession's long range effort to keep medical care on a voluntary basis. This effort will continue as long as attempts are made to shackle the people's health in bureaucratic red tape.

"Mr. Truman is naive indeed if he believes that any speech he delivers could change the medical profession's basic beliefs concerning high quality medical care."

First Winslow Lecture

The first C.-E. A. Winslow Lecture will be given in Strathcona Hall, Yale University, corner of Grove and Prospect Streets, New Haven, on Friday, November 14, 1952, at 4:00 P. M., by the Surgeon General of the U. S. Public Health Service, Dr. Leonard Scheele. The subject will deal with Looking Ahead in World Health, and will consider special opportunities in the United States in relation to education, training, health and hospital practices. The Winslow Lectureship was established by the Alumni at the time of Professor Winslow's retirement as chairman of Public Health at Yale, a post which he had held since the development of the Department in 1915.

Dr. Scheele is a graduate of the Michigan School of Medicine, a former chief of the Cancer Program of the Public Health Service and a former representative of Medical Civil Defense for the western area of the United States just preceding assignment to medical military duties during World War II. Following his military service in the U. S. Army in Italy, Dr. Scheele became head of preventive medicine and communicable disease control for military government—civil affairs in Europe for General Eisenhower's Headquarters, SHAEF. Among numerous decorations, Dr. Scheele received the U. S. Typhus Commission Medal. He has played an important and leading role in the World Health Organization and is now serving on his second term appointment as Surgeon General.

SPECIAL NOTICES

YALE MEDICAL SOCIETY

The Yale Medical Society includes in its membership all of the faculty of the Yale University School of Medicine and the staff of the Grace-New Haven Community Hospital. Officers and councillors of the Society are elected by and from the membership at the last meeting of each year.

Meetings are usually held at 8:15 P. M. on the second Wednesday of every month from October to May inclusive. Four meetings are devoted to the presentation of scientific work from all departments of the School of Medicine. The time allotted for the presentation of each of several papers at these meetings is fifteen minutes. Four meetings are each devoted to an address by a distinguished visitor from some other institution. An attempt will be made to arrange programs which will be varied and interesting.

LECTURES ON CARDIOVASCULAR DISEASE

The Stamford Heart Association announces a monthly series of lectures on cardiovascular disease for physicians in Fairfield County beginning in October.

Speakers will include: Drs. Paul Beeson, Howard Sprague, Andre Cournand, Charles Bailey, Harry Gold and Thaddeus Danowski.

The course is accredited and endorsed by the Stamford Academy of General Practice and Stamford Medical Society. There is no fee for this series.

The Stamford Heart Association also announces the initiation of monthly Cardiac Clinic conferences at Stamford Hospital with Dr. Ruth Whittemore, associate clinical professor in pediatrics, Yale University School of Medicine, and Dr. H. M. Marvin, associate clinical professor of medicine, Yale University School of Medicine, acting as consultants on alternate months. Physicians in the Stamford area are invited to attend.

For further information on the above announcements contact Mrs. Shirley Sarkin, executive secretary, Stamford Heart Association, Stamford Hospital.

NEW YORK MEDICAL COLLEGE
Flower and Fifth Avenue Hospitals

Division of Graduate Studies announces special courses in Fertility and Sterility. Department of Obstetrics and Gynecology.

SCHEDULED COURSES OFFERED

OG/FS1: GENERAL FERTILITY AND STERILITY

A full time two-week intensive course covering the entire subject of the infertile couple. (See schedule and outline). The course will start: October 20, 1952; February 9, 1953; May 11, 1953; October 12, 1953. Fee $200.

OG/FS-2: ADVANCED COURSE IN FALLOPIAN TUBE PHYSIOLOGY, PATHOLOGY, DIAGNOSIS AND TREATMENT

A part time two-week intensive comprehensive course including every aspect of fallopian tube disorder, its diagnosis and treatment in relation to the infertile female. (See outline). The course will start: November 3, 1952; February 24, 1953; June 1, 1953; October 26, 1953. Fee $150.

OG/FS-3: ADVANCED COURSE IN CULDOSCOPY IN STERILITY

A part time two-week intensive and inclusive course encompassing the use of the culdoscope in female sterility diagnosis and treatment. (See outline). The course will start November 3, 1952; February 24, 1953; June 1, 1953; October 26, 1953. Fee $150.

OG/FS-4: ADVANCED COURSE IN ENDOMETRIAL BIOPSY AND OVULATION

A part time two-week complete course in human ovulation and its histopathologic variations. (See outline). The course will start: November 3, 1952; February 24, 1953; June 1, 1953; October 26, 1953. Fee $150.

OG/FS-5: ADVANCED COURSE IN SEMEN AND SEMEN ANALYSIS

A part time one-week all-inclusive course taking in every aspect of semen in relation to marital infertility and modern aspects of semen evaluation and interpretation. (See outline). The course will start: November 3, 1952; February 24, 1953; June 1, 1953; October 26, 1953. Fee $75.

OG/FS-6: ADVANCED COURSE IN OPERATIVE (REPARATIVE AND RESTORATIVE) GYNECOLOGY IN STERILITY

A part time two-week course covering the surgical aspects of restoring fertility to the infertile female. (See outline). The course will start: November 3, 1952; February 24, 1953; June 1, 1953; October 26, 1953. Fee $150.

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY
Program for November 1952

November 6

Tuberculosis Control in Connecticut

Dr. Paul S. Phelps, director, Tuberculosis Commission, State of Connecticut

November 13

The Chemotherapy of Tuberculosis—November 1952

Dr. Paul Kunkel, chief of medicine, Veterans Hospital, Newington

Meetings are held at 8:30 A. M. in the Conference Room at 95 Pearl Street, Hartford; all interested physicians are cordially invited

November 20

ANNUAL DINNER MEETING at Heublein Hotel, 7:00 P. M.

Evaluation of Excisional Surgery in the Treatment of Pulmonary Tuberculosis

Dr. R. Leonard Kembler, attending thoracic surgeon, Cedarcrest Sanatorium

WOMAN'S AUXILIARY TO MEET IN NOVEMBER

The ninth annual conference of state presidents, presidents-elect, and national committee chairmen of the Woman's Auxiliary to the American Medical Association will be held at the La Salle Hotel, Chicago, November 6-7. The theme of the conference wil be "Our Goal . . . A Better World."

The agenda includes a report of the president, panels on the organization, program, nurse recruitment, civil defense, *Today's Health*, American Medical Education Foundation, public relations and community service, and legislation, and question and answer periods.

CONNECTICUT TRUDEAU SOCIETY

Julius L. Wilson, professor of medicine, Henry Phipps Institute, University of Pennsylvania, and chief of the Bureau of Tuberculosis Control for the Commonwealth of Pennsylvania, will be the moderator for the scientific program at the annual meeting of the Connecticut Trudeau Society in New Haven on November 20.

Dr. Wilson is well known in Connecticut, having been on the staff of the William Wirt Winchester Hospital in New Haven, when he left to accept a position as professor of Clinical Medicine, Tulane University, New Orleans. He is a past president of the American Trudeau Society, the medical section of the National Tuberculosis Association.

The program will be in the form of a "Pembine" discussion, at which the medical staffs of Undercliff and Cedarcrest Sanatoria will present tuberculosis case reports for discussion by the members of the Society. The meeting will be held at Farnam Auditorium, Yale University School of Medicine, from 2:00 to 6:00 in the afternoon and from 8:00 to 10:00 in the evening. Both the afternoon and evening sessions will provide complete case summaries, for the convenience of those who cannot attend the whole program. All interested physicians are invited to attend.

CONNECTICUT STATE SOCIETY OF ANESTHESIOLOGISTS

The Fall Meeting of the Connecticut State Society of Anesthesiologists will be held in Middletown on Tuesday evening, November 25, 1952.

Dr. William S. Derrick, associate in anesthesia, Harvard Medical School, and anesthesiologist at the Peter Bent Brigham Hospital, Boston, Massachusetts, will speak on "Cortisone, ACTH, and Anesthesia."

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS, UNITED STATES PUBLIC HEALTH SERVICE

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on January 6, 7, and 8, 1953. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received no later than November 25, 1952.

The Regular Corps is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, etc.

Appointments will be made in the grades of assistant surgeon (equivalent to Navy rank of Lt., j.g.) and senior assistant surgeon (equivalent to lieutenant-. In making assignments, consideration is given to the officer's preference, ability, and experience; however, all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service. Appointments are permanent in nature and provide opportunities to qualified physicians for a life career in clinical medicine, research, and public health. Applicants who successfully complete this examination may ordinarily expect appointment as soon as they become eligible.

REQUIREMENTS

Both grades: United States citizenship. At least 21 years of age. Graduation from a recognized school of medicine.

Assistant surgeon: At least seven years of collegiate and professional training and appropriate experience.

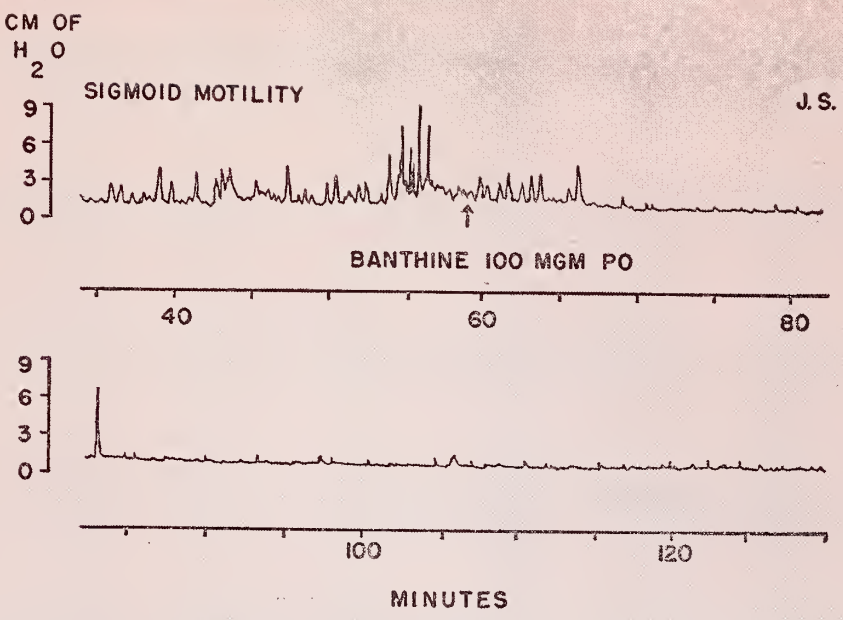
Senior assistant surgeon: At least ten years of collegiate and professional training and appropriate experience.

Applicants who will meet these qualifications within nine months of the date of the written examination will be admitted, but may not be appointed until they fulfill the requirements. Physicians who are successful in the examination and are now serving internships will not be placed on active duty in the Regular Corps until completion of internship. The examination will include an oral interview, physical examination, and written objective tests covering the professional field. A copy of the applicant's birth certificate and of transcripts covering all undergraduate and professional education must accompany application forms.

The written professional examination for the grade of assistant surgeon will cover the following material: basic medical sciences, including anatomy, physiology, biochemistry, microbiology, and pathology; practice of medicine, including internal medicine (including neurology and psychiatry), therapeutics and toxicology, pediatrics, and medical problems of obstetrics and gynecology; practice of surgery, including surgery, orthopedics, gynecology, obstetrical procedures; and preventive medicine and public health. The examination for senior assistant surgeon will include the above subjects with the exception of anatomy.

PHYSICAL REQUIREMENTS

Candidates must be found physically qualified as a result of an examination performed at a Public Health Service



The effect of 100 mg. of Banthine on sigmoid motility. The contractions did not return during the experimental period.[1]

In Intestinal Hypermotility—Banthine®

"...has a prolonged inhibitory effect on human gastrointestinal motility....
The duration of its action is striking,...."[1]

It has also been observed that definite retardation in gastrointestinal transit time in individuals with hypermotility was attributable to the therapeutic effect of Banthine.[2]

BANTHINE® Bromide (brand of methantheline bromide)—a true anticholinergic—is available for oral and parenteral use.

1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β-Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), Am. J. Med. *11*:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

facility. The physical standards for appointment to the Commissioned Corps are relative high. Candidates who have a physical defect, or who have had serious illness or injury, should attach a statement to their applications outlining in detail the nature of such illnesses or injuries, treatment received, periods of hospitalization, length of absence from work, and present status.

Gross pay is identical to that of officers of equivalent rank in the Army and Navy. Entrance pay for an assistant surgeon with dependents is $6,017 per annum; for senior assistant surgeon with dependents, $6,918. These figures include the $1,200 annual additional pay received by Medical Officers as well as subsistence and rental allowance.

PROMOTIONS

Provisions are made for promotion at regular intervals up to and including the grade of senior surgeon (Commander) and for promotion by selection to the grade of medical director (Captain).

Retirement pay after 30 years of service or at age of 64 is three-fourths of annual basic pay at the time of retirement. Minimum disability retirement pay is ordinarily one half of annual basic pay at the time of retirement.

Additional benefits include periodic pay increases (time served as a member of the armed forces is credited), 30 days annual leave, sick leave, full medical care, and other privileges.

Application forms and additional information may be obtained by writing to the chief, Division of Commissioned Officers, Public Health Service, Federal Security Agency, Washington 25, D. C. Completed application forms must be received in the Division of Commissioned Officers no later than November 25, 1952. Applications received after that date may not be accepted and will be returned to the applicant.

FELLOWSHIP OPENINGS FOR 1953-54 ANNOUNCED BY NRC

December 10 is deadline for receipt of applications for postdoctoral research fellowships beginning in 1953, according to announcement by Division of Medical Sciences, National Research Council. Sponsors of awards include Rockefeller Foundation, Lilly Research Laboratories, National Tuberculosis Association and James Picker Foundation. Details and application blanks are obtainable from Fellowship Office, National Research Council, 2101 Constitution Avenue N.W., Washington, D. C.

AMERICAN ACADEMY OF OB-GYN. HOLDS FIRST CLINICAL SESSION

The First Annual Clinical Session of the American Academy of Obstetrics and Gynecology will be held December 15-17 at the Palmer House, Chicago.

The meeting will feature six general sessions and 48 discussion groups of 40 Fellows each. There also will be at least 15 new scientific exhibits and about 60 technical displays.

The annual banquet Tuesday evening, December 16, will feature an address by the retiring president, Carl P. Huber of Indianapolis. The first truly national organization in its field, the Academy was incorporated August 14, 1951 and already has some 2,400 qualified Fellows.

Election of officers will take place at the annual business meeting Tuesday morning.

Program chairman is Ralph A. Reis of Chicago.

RURAL HEALTH MEETING DATES SET

The AMA Council on Rural Health has announced that its eighth national conference will be held at the Roanoke Hotel, Roanoke, Virginia, February 27-28.

The theme of the '53 meeting will be: "Widening the Highway to Health."

Chairman F. S. Crockett, Lafayette, Indiana, said that the program is being built around such subjects as the place of dental care in the rural health program; financing rural medical care, including specific stories of successful accomplishment; how various rural medical care projects have been developed and carried out at the community level, and how similar projects may be put into operation.

Council secretary Arline Hibbard reports that on Thursday, February 26—the day preceding the formal sessions—members of state rural health committees and committees handling rural health matters will get together at an informal meeting to take up the problem of "Doctor Participation in Community Programs." Doctors at this session will have an opportunity to talk over their problems, exchange experiences and discuss possible activities and programs, putting particular emphasis on community affairs.

THE INTERNATIONAL ACADEMY OF PROCTOLOGY 1952 AWARD CONTEST

The International Academy of Proctology takes pleasure in announcing its Annual Cash Prize and Certificate of Merit Award Contest for 1952-1953. The best unpublished contribution on proctology or allied subjects will be awarded $100 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit.

This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contributions will be selected by a board of impartial judges, and all decisions are final.

The formal award of the first prize, and a presentation of other certificates, will be made at the Annual Convention Dinner Dance of the International Academy of Proctology in May of 1953.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, *The American Journal of Proctology and Gastroenterology*.

All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of April, 1953. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing 55, New York.

FOLIO FOUNDATION OFFERS FELLOWSHIPS

The National Foundation for Infantile Paralysis announces the availability of a limited number of additional postdoctural fellowships to candidates whose interests are research and teaching in medicine and the related biological and physical sciences. The purpose of these National Foundation fellowships is to increase the number of professional workers qualified to give leadership in the solution of basic and clinical research problems of poliomyelitis and other crippling diseases.

The fellowships cover a period of from one to five years. Stipends to Fellows range from $3,600-$7,000 a year, with marital and dependency status considered in determining individual awards. Institutions which accept Fellows receive additional compensation for expenses incurred in relation to their training programs.

Eligibility requirements include United States citizenship (or the declared intention of becoming a citizen), sound health and an M.D., PH.D., or an equivalent degree.

Selection of candidates is made by a Fellowship Committee composed of leaders in the fields of research and professional education. The designation "Fellow of The National Foundation for Infantile Paralysis" will be given to successful candidates.

A total of 144 fellowship awards in these categories has been made by the National Foundation up to August 31, 1952.

Complete information concerning qualifications and applications may be obtained from: Division of Professional Education, The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

In very special cases
A very superior Brandy



Specify 84 Proof

★ ★ ★

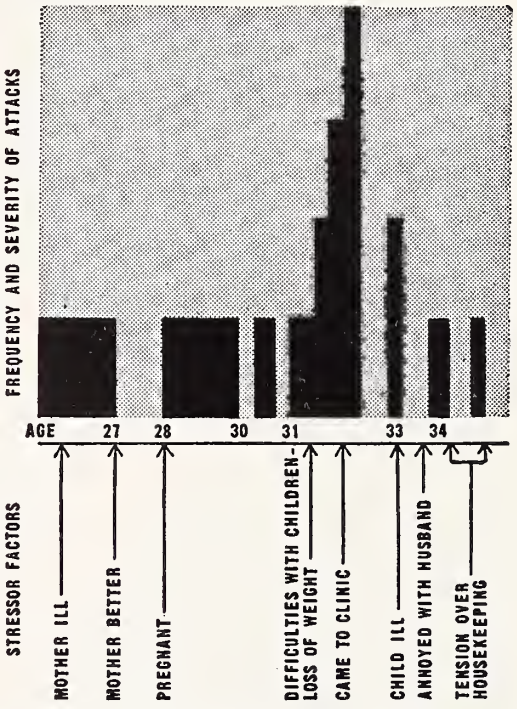
HENNESSY

THE WORLD'S PREFERRED
COGNAC BRANDY

Schieffelin & Co., New York N.Y.

Stress . . .

Stressor factors which evoke autonomic responses occur often in our civilization. They are not always of external origin, frequently, stress springs from the "well of uncertainties, the fears, the angers, and the hostilities that an inadequate childhood nurtures in troubled people in a troubled world."[1]



After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. 4: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

Incessant "emotional buffeting" impinged on labile autonomic pathways is likely to produce deviations from normal body function and *a rash of symptoms.* In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are: belladonna alkaloids, ergotamine tartrate and phenobarbital. These drugs may be used individually or in combination,* as required by the individual case, to effect more stable function of the autonomic nervous system, thereby "dampening" overactivity of the involved organ systems.

* Dosage of each ingredient adjusted to the needs of the particular patient.

[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

Important Announcement on Veterans Medical Care

The Veterans Administration budget for medical and dental services has been cut to the extent of 31 million dollars during the current fiscal year. As a result, all programs in Hospitals, Regional Offices and Centers have had to be curtailed.

Of particular interest to fee basis physicians, funds available are approximately two-thirds of the amount estimated as necessary for the usual number of requests for treatment authorizations. Therefore, it will be necessary to establish some sort of priority because it will not be possible to approve all requests.

The Veterans Administration does not presume to know which of the eligible veterans under physician's care most need treatment, and is reluctant to make any arbitrary decision. It is recognized that the physician alone can determine the need for and extent of therapy in each case.

The cooperation of all fee basis physicians is requested by the Administration to establish the priority for treatment of veterans who come under their care.

In the event that these priorities are not designated by physicians, the only alternative will be for the Veterans Administration to grant priority to requests which appear to be most urgent.

NEW BOOKS IN REVIEW

MEDICAL BIOGRAPHIES The Ailments of Thirty-Three Famous Persons. By Philip Marshall Dale, M.D. *Norman University of Oklahoma Press.* 1952. 259 pp. $4.

Reviewed by Stanley B. Weld

To those who are interested in the ills which beset the human race and ultimately result in death, this collection of sketches will afford several hours of entertaining reading. The author has utilized a vast amount of source material from which to develop his portraits and draw his own conclusions.

The list of characters selected is an imposing one, varied as to era and nationality, and includes a single individual, Buddha, who lived before Christ. Selections have been made from the great of Europe during the last three or four centuries, such as Samuel Pepys, Dean Swift, Catherine the Great and Guy de Maupassant. And from our own nation our Presidents Washington, Jackson, Garfield, Cleveland and McKinley, and in addition, Nancy Hanks Lincoln, Walt Whitman and Edgar Allan Poe are portrayed with medical data included with which many readers will find they were entirely unfamiliar.

It is an interesting volume. The author has labored long. His language is couched in terms which should be readily understood by layman as well as physician. Among the references may be found the name of Connecticut's Henry F. Stoll who published An Early Case of Coronary Thrombosis Not Hitherto Reported two years before his own untimely death.

"Whether by philosophy, creed, or simple resignation, he who has conquered the fear of death has, in a humanistic sense, conquered death itself."

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through Journal
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years,* are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

FOR SALE—New Beck-Lee String Type Electrocardiograph Including Mobile Cabinet $125. New McKesson Waterltss Basal Metabolism $175. Practically new Jones Basal Metabolism $200. Birtcher-Bandmaster Short Wave FCC License $350, like new. Satisfaction guaranteed—5 day trial. Phone Meriden 5-9675 or write Harry Sacker, P. O. Box 642, Meriden, Connecticut.

FOR SALE—Large stock of New and Refinished Equipment and instruments available for the Physician, Hospital and Laboratory at a savings from 50 to 75 per cent. Hamilton Wood Treatment Room Furniture, excellent condition. EENT chairs and instruments, sterilizers and cabinets, Diagnostic Sets. Baumonometers, Scales, Imperatori Suction Pressure Unit. Green Illuminated Eye Testing Cabinet. Microscopes $100 up. One year guarantee. Phone Meriden 5-9675 or write Harry Sacker, P. O. Box 642, Meriden, Connecticut.

FOR SALE—RURAL Home, for sale, ideal for rural medical practice. Within twenty (20) minutes from Bridgeport and ten (10) minutes from Danbury. Nine rooms, two baths and large knotty pine office. House completely equipped with all modern conveniences. For further details call Bridgeport 6-1846.



DON'T MISS 

APPEARING REGULARLY IN THE J. A. M. A.

AMERICAN MEDICAL EDUCATION FOUNDATION

FUND-RAISING COMMITTEE

CONNECTICUT STATE MEDICAL SOCIETY

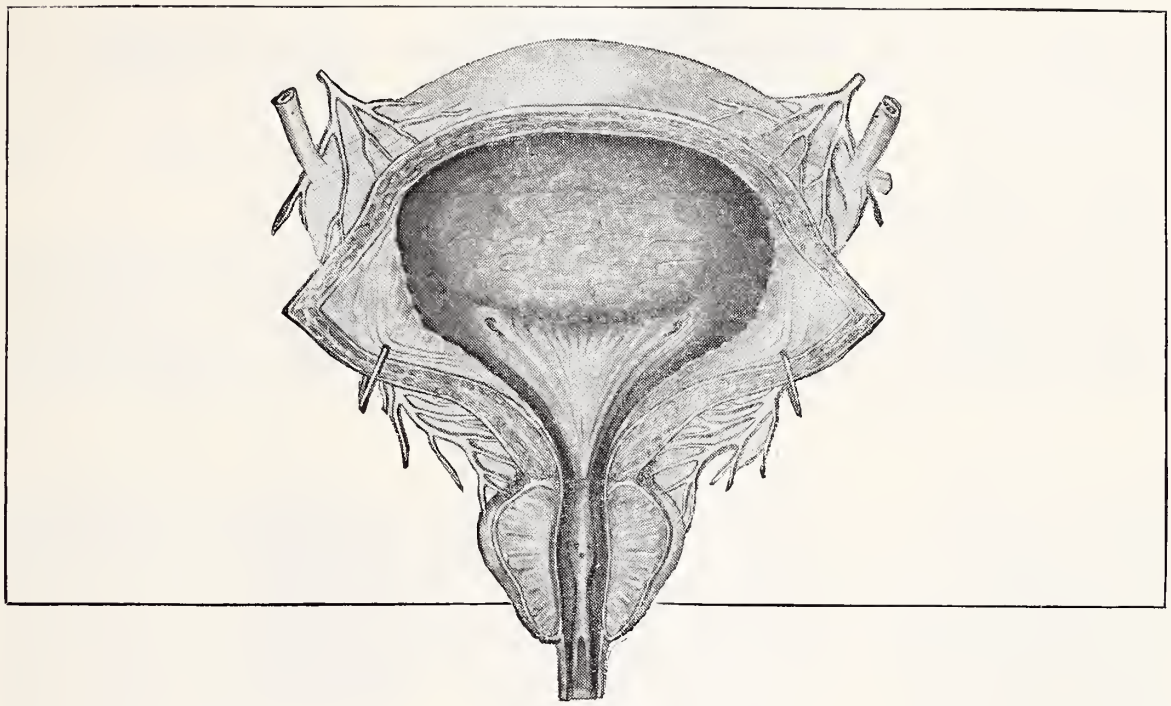
Physicians who have contributed in the current campaign and those who have indicated they are contributing directly to their medical schools as of October 2, 1952

FAIRFIELD COUNTY

Meyer Abrahams, New Canaan
Payson B. Ayres, Cos Cob
Joseph H. Beaudry, Bridgeport
Sidney H. Beck, Bridgeport
Maxwell Bogin, Bridgeport
John D. Booth, Danbury
Eugene D. Brochu, Danbury
Claudius V. Calvin, Bridgeport
Philip R. Carroll, Jr., Bridgeport
Edwin R. Connors, Bridgeport
Francis M. Conway, Danbury
William H. Curley, Bridgeport
Rector T. Davol, Greenwich
Irving S. Dichter, Stamford
Dean H. Edson, Danbury
Ralph H. Edson, Shelton
J. Benton Egee, Newtown
C. Louis Fincke, Stamford
Joseph Fine, Stamford
Wesley F. Fitzpatrick, Norwalk
David H. Fogel, Stamford
Winifred K. Freeman, Greenwich
John G. Frothingham, New Canaan
Thomas H. Gaetz, Shelton
William A. Geer, Bridgeport
Harold Genvert, Norwalk
Donald F. Gibson, Danbury
Frank M. Goldys, Danbury
Grace V. Gorham, Norwalk
Vincent A. Gorman, Bridgeport
Daniel P. Griffin, Bridgeport
John E. Grigas, Greenwich
Arthur S. Griswold, Bridgeport
Crawford Griswold, Bridgeport
R. Warren Hall, Trumbull
James V. Halloran, Greenwich
Francis M. Harrison, Stamford
George W. Hebard, New Canaan
Robert B. Hiden, New Canaan
J. Brooks Hoffman, Greenwich
Joseph H. Howard, Bridgeport
A. Boswell James, Bridgeport
Leon Kaplan, Bridgeport
Russell A. Keddy, Darien
Walter W. Kemp, Stamford
Marjorie S. Knauth, Wilton
Neil F. Lebhar, Westport
Paul Lengyel, Bridgeport
R. Harold Lockhart, Bridgeport
Jane Lockwood, Greenwich
Edward J. Lynch, Shelton
Frederick W. McFarland, Stamford
John D. McMahon, South Norwalk
Henry J. Murray, Stamford
Louis Newton, Bridgeport
Robert A. Northrop, Norwalk
Frank T. Oberg, Bridgeport
Ralph L. Parker, Bridgeport
Frederick A. Patterson, Norwalk
Morris P. Pitock, Bridgeport
John S. Poczabut, Stamford
Joseph C. Quatrano, Bridgeport
Katherine S. Quinn, Bridgeport
Cotton Rawls, Stamford
Harold Ribner, Bridgeport
Edward R. Roberts, Bridgeport
Joseph E. Savak, Springdale
Michael V. Sciortino, Bridgeport
Howard P. Serrell, Greenwich
Milton Sheiman, Bridgeport
Samuel C. Sheiman, Bridgeport
Homer B. Shoup, Westport
Alan R. Small, Bridgeport
Joseph J. Smith, Bridgeport
Nicholas V. Spinelli, Bridgeport
Charles H. Sprague, Bridgeport
Eric E. Stietzel, South Norwalk
Luther M. Strayer, Bridgeport
Oliver L. Stringfield, Stamford
Saul Thomases, Stratford
George L. Tunick, Greenwich
Frank Turchik, Bridgeport
Edward J. Wagner, Ridgefield
Ellwood C. Weise, Bridgeport
Dexter Wolfson, Bethel
Francis B. Woodford, Ridgefield
Robert H. Wyatt, Stamford
Isidore Yasser, Bridgeport
John B. Zielinski, Bridgeport

HARTFORD COUNTY

John C. Allen, Hartford
Egbert M. Andrews, Hartford
Norman Barker, Hartford
Preston N. Barton, Terryville
Israel Beatman, Hartford
Alfred J. Berger, New Britain
Edmund Beizer, Hartford
Charles T. Bingham, Rocky Hill
Howard Boyd, Manchester
Francis J. Braceland, Hartford
Donald A. Bristoll, New Britain
Francis S. Buccheri, New Britain
Burdette J. Buck, Hartford
Maudie Marie Burns, West Hartford
Walter L. Butterfield, Hartford
John E. Cartland, Hartford
Lewis L. Chester, Hartford
Ettore F. Carniglia, Hartford
Timothy L. Curran, Hartford
Walter A. Dalmain, Bristol
Marvin B. Day, Hartford
Edward G. Deming, Hartford
William J. Doerr, Hartford
Ralph E. Durkee, Hartford
Sidney D. Eisenberg, New Britain
Ralph M. Filson, West Hartford
Amos E. Friend, Manchester
Edward M. Finesilver, Hartford
James C. Fox, Jr., Hartford
John N. Gallivan, East Hartford
Isidore S. Geeter, Hartford
Forrest D. Gibson, Hartford
J. Raymond Glazier, Hartford
Howard W. Gourlie, Thompsonville
Leroy C. Grau, Hartford
Dwight Griswold, Hartford
George M. Gura, Southington
Jack Gurwitz, Hartford
Louis D. Harris, Hartford
Francis W. Helfrick, Manchester
Carl S. Hellijas, Wethersfield
Harold A. Howard, Wethersfield
Glover E. Howe, Hartford
Charles E. Jacobson, Hartford
Derick A. January, Hartford
Joseph F. Jenovese, Hartford
James C. Johnson, Hartford
Frank S. Jones, Hartford
Robert H. Karotkin, Hartford
Robert R. Keeney, Manchester
John J. Kennedy, Jr., Windsor Locks
Isaac W. Kingsbury, Hartford
Joseph Klein, Hartford
Irving H. Krall, Hartford
William J. Lahey, Hartford
R. Starr Lampson, Hartford
J. Whitfield Larrabee, Hartford
John C. Leonard, Hartford
Howard J. Lockward, Manchester
Raymond D. Lublin, East Hartford
George A. F. Lundberg, Manchester
Francis L. Lundborg, West Hartford
William H. MacCready, Windsor
Morris M. Mancoll, Hartford
Edward Martin, New Britain
Stevens J. Martin, Hartford
Nicholas A. Mastronarde, Hartford
Donald J. McCrann, Hartford
Martin P. McCue, Hartford
Sidney R. McPherson, Hartford
James R. Miller, West Hartford
Joseph A. Mlynarski, New Britain
Philip J. Moorad, New Britain
Michael J. Morrissey, Hartford
John O. Nolan, Hartford
Harriett E. Northrup, West Hartford
Stanley H. Osborn, West Hartford
Robert H. Osmond, Hartford
Salvatore S. Piacente, Hartford
Maurice M. Pike, Hartford
William H. Pomeroy, Poquonock
Foster E. Priddy, Wethersfield
John V. Prignano, Manchester
Sidney S. Quarrier, Hartford
John F. Reed, Hartford
Renato A. Ricca, Glastonbury
Frederick P. Rogers, West Hartford
John C. Rowley, West Hartford
Merril B. Rubinow, Manchester
Charles T. Schechtman, New Britain
William B. Scoville, Hartford
Daniel E. Shea, Hartford
Marguerite D. Shepard, Newington
Warren B. Silliman, Windsor
Wilson F. Smith, Hartford
George W. Sorokowski, East Hartford
E. Myles Standish, Hartford
Hilda C. Standish, Hartford
James H. Standish, Hartford
Theodore W. Steege, Hartford
William F. Storms, Wethersfield
Hartwell G. Thompson, Hartford
Ralph M. Tovell, Hartford
William H. Upson, Suffield
Euen VanKleeck, Hartford
N. William Wawro, Hartford
Sylvia Weiner, Hartford
Stanley B. Weld, Hartford
Gideon R. Wells, Hartford
Benjamin B. Whitcomb, Hartford
Benjamin V. White, Hartford
Otto G. Wiedman, Hartford
William M. Wiepert, Avon
John T. Winters, West Hartford
Harold B. Woodward, Bristol
Thacher W. Worthen, Hartford
Raymond Yesner, Newington
Edmond R. Zaglio, Manchester
Oscar H. Zarkin, Hartford
Norman Zeldis, Hartford



Retention Relieved Pharmacodynamically

URECHOLINE® is highly effective in the prevention and control of bladder dysfunction including postoperative urinary retention. It increases muscular tone of the bladder and produces a contraction sufficiently strong to initiate micturition and empty the bladder. Encouraging results also have been reported following the use of URECHOLINE in gastric retention, abdominal distention, and megacolon.

Reprint of recent clinical report available on request

URECHOLINE® Chloride

(Bethanechol Chloride Merck)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada: MERCK & CO. Limited—Montreal

© Merck & Co., Inc.

LITCHFIELD COUNTY

George L. Cushman, North Woodbury
Thomas J. Danaher, Torrington
Meredith M. Dickinson, Watertown
William G. H. Dobbs, Torrington
G. Robert Downie, Winsted
Louis E. Garston, Torrington
Harry B. Hanchett, Torrington
Arthur H. Jackson, Washington
William B. Lyons, Thomaston
Andrew W. Orlowski, Torrington
Edwin G. Reade, Watertown
A. Rocke Robertson, Torrington
Daniel P. Samson, Thomaston
Roy V. Sanderson, Winsted
Hope Sherman, Pleasant Valley
James T. Smith, Winsted
Francis A. Sutherland, Torrington
Frank D. Ursone, Norfolk
Floyd A. Weed, Torrington
Edward H. Wray, Jr., Litchfield

MIDDLESEX COUNTY

William F. Bauer, Jr., Middletown
Harriet Bixby, Mansfield Depot
Willard E. Buckley, Middletown
Frank H. Couch, Cromwell
G. Mansfield Craig, Middletown
Clair B. Crampton, Middletown
Harry S. Frank, Middletown
Norman H. Gardner, East Hampton
Richard F. Grant, Cromwell
Carl C. Harvey, Middletown
Walter R. James, Essex
John J. Korab, Middletown
Louis O. LaBella, Middletown
Christie E. McLeod, Middletown
Benjamin A. Roccapriore, Middletown
V. Gerard Ryan, Portland
Henry Sherwood, Middletown
Archibald W. Thomson, Middletown
F. Erwin Tracy, Middletown
Sophie C. Trent, Middlefield
Vincent J. Vinci, Middletown
Harry S. Whiting, Middletown
William E. Wrang, Middletown

NEW HAVEN COUNTY

Elisabeth C. Adams, Guilford
Edward P. Allen, New Haven
Creighton Barker, New Haven
Walter E. Barney, Milford
Sidney Berman, Stratford
Courtney C. Bishop, New Haven
Samuel P. W. Black, New Haven
Eugene M. Blake, New Haven
Dana L. Blanchard, Branford
George Blumer, San Marino, Calif.
Joseph J. Bowen, Jr., Waterbury
Eugene B. Brody, New Haven
George D. Burns, Derby
Norton Canfield, New Haven
William C. Carey, Meriden
Anthony L. Carpentieri, Waterbury
John A. Chasnoff, West Haven
Jules V. Coleman, New Haven
Joseph O. Collins, Waterbury
Michael J. Conroy, Meriden
David F. Conway, Jr., New Haven
C. James Coppeto, Waterbury
Morris Coshak, Waterbury
Thomas Cottiero, Waterbury
Edward C. Curnen, Jr., New Haven
Hermann S. Cutler, New Haven
Marion Dallas, New Haven
Arthur B. Dayton, New Haven
Clyde L. Deming, New Haven
Theodore S. Evans, New Haven
Samuel E. Fabricant, Waterbury
William Finkelstein, Waterbury
Joseph A. Fiorito, New Haven
William J. H. Fischer, Milford
Morris Freedman, New Haven
Clements C. Fry, New Haven
Russell V. Fuldner, New Haven
Henry A. Geib, Milford
Arthur J. Geiger, New Haven
William J. Goade, Boston, Mass.
Morris Goldstein, New Haven
William M. Good, Waterbury
Frank D. Gray, New Haven
Frieda G. Gray, New Haven
William Grillo, Waterbury
Francis P. Guida, New Haven
L. Jennings Hampton, New Haven
Morris A. Hankin, New Haven
John E. Harty, Waterbury
Albert E. Herrmann, Waterbury
Maurice M. Hillman, New Haven
Clayton H. Hitchins, New Haven
Samuel A. Jaffe, New Haven
Mary L. James, North Haven
Carl E. Johnson, New Haven
Robert H. Jordan, New Haven
Lester G. Joseph, New Haven
LeMoyne C. Kelly, Waterbury
John J. Kennedy, Jr., Windsor Locks
Leo W. Koster, West Haven
Henry Krochmal, Meriden
Samuel D. Kushlan, New Haven
Michael H. Lavorgna, New Haven
Maxwell Lear, New Haven
Jerome A. L'Heureux, Meriden
J. David McGaughey, III, Wallingford
J. Wister Meigs, New Haven
Anthony J. Mendillo, New Haven
Henry Merriman, Waterbury
W. Haviland Morriss, Wallingford
Harold F. Morrill, Waterbury
Thomas P. Murdock, Meriden
Richard Newman, New Haven
Edward W. Oxnard, Cheshire
Else Pappenheim, New Haven
Gioacchino S. Parrella, Milford
Louis A. Parrella, North Haven
Harry F. Pennington, Meriden
Samuel Philipson, New Haven
George J. Piazza, New Haven
John P. Riesman, New Haven
Milo P. Rindge, Madison
Orville F. Rogers, New Haven
J. Harold Root, Waterbury
Benjamin B. Rosenthal, Milford
Allan J. Ryan, Meriden
A. Lewis Shure, New Haven
Jasper H. Smith, Waterbury
John S. Staneslow, Waterbury
Harold Strickland, Meriden
Morgan Y. Swirsky, New Haven
Wilder Tileston, New Haven
Alexander B. Timm, Jr., Milford
Leo L. Tylec, Naugatuck
J. Alexander VanHeuven, New Haven
Paul Vestal, New Haven
J. Alfred Wilson, Meriden
Paul Winer, New Haven
Arthur M. Yudkin, New Haven

NEW LONDON COUNTY

Mario J. Albamonti, Norwich
Henry A. Archambault, Taftville
Frederick C. Barrett, Jewett City
Harold A. Bergendahl, Norwich
Hugh B. Campbell, Norwich
Frederick J. Fagan, New London
Louis Guss, Norwich
Frederick B. Hartman, New London
Robert T. Henkle, New London
Morris E. Katz, Norwich
Winfield O. Kelley, Norwich
Warren W. LaPierre, Norwich
Joseph J. Mahoney, Norwich
Frank J. Miselis, Uncasville
Martin L. O'Neil, Jewett City
David G. Rousseau, Taftville
Thomas Soltz, New London
Richard M. Starr, New London
John W. Suplicki, Norwich
Paul Sutton, Groton
S. Paul Tombari, Waterford
Harold D. VonGlahn, Old Lyme
Carl H. Wies, New London

TOLLAND COUNTY

Seymour I. Kummer, Rockville
Wendelin G. Luckner, Stafford Springs
Elliott H. Metcalf, Rockville

WINDHAM COUNTY

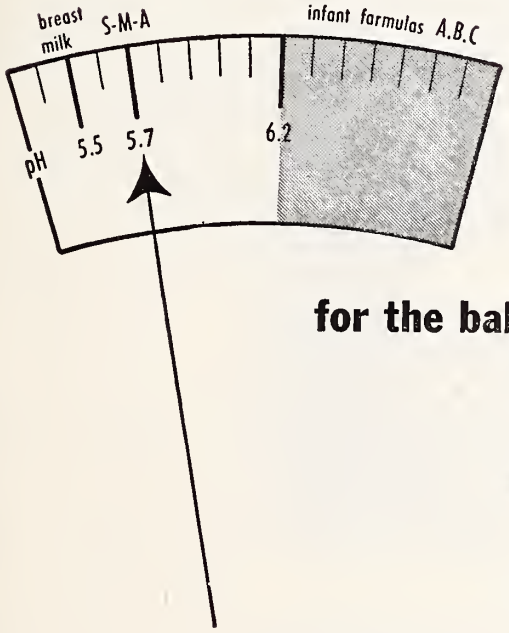
Gerard M. Chartier, Danielson
Ralph Gilman, Storrs
J. Arthur Girouard, Willimantic
Angelo J. Gulino, Plainfield
Winston C. Hainsworth, Willimantic
Andrew O. Laakso, Danielson
Mervyn H. Little, Willimantic
Olga A. G. Little, Willimantic
James W. Major, Willimantic
Sawyer E. Medbury, Willimantic
Richard V. Newcombe, Willimantic
Edward J. Ottenheimer, Windham
Karl T. Phillips, Putnam
Brae Rafferty, Willimantic
William M. Shepard, Putnam
Nathan M. Spector, Willimantic
Jean K. Stevenson, Thompson
Bruce R. Valentine, Abington
John A. Woodworth, Moosup

clinical tests show S-M-A®

is the only infant feeding formula that



- establishes a predominantly gram-positive flora—similar to the flora of the lower intestine of the breast-fed baby.[1]



- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

for the baby S-M-A means:

1 *Better absorption of minerals, especially calcium.*

2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

3 *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.

4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin B_{12}.* Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. *40*:152 (Feb.) 1952.
2. Lichtman, H., Ginsberg, V., and Watson, J.: Proc. Soc. Exp. Biol. and Med. *74*:884 (Aug.) 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

Wyeth®

OUR NEIGHBORS

Massachusetts

The bill for a state medical school in Massachusetts failed to pass the Senate by the close vote of 18 to 16. The bill had previously passed the State House of Representatives. With a ratio of one physician for every 538 persons, Massachusetts would seem to be well supplied and not in need of another medical school.

According to the AMA Direcotry, Massachusetts has 35 per cent of its physicians in general practice and 38 per cent in specialties. According to *Norfolk Medical News* the need is not for more physicians but for more general practitioners. It offers three suggestions for increasing the supply of G.P.'s: (1) More general practitioners on medical school faculties as preceptors; (2) rotating hospital internships or supplementary general practice training for interns; (3) encouragement of more students to qualify for the Academy of General Practice rather than certification by specialty boards.

Vermont

At the recent annual meeting of the Vermont State Medical Society held at Bretton Woods, N. H., in conjunction with the New Hampshire Medical Society, all the living past presidents of the Society were presented with certificates, signed, framed and bearing the gold seal of the Society. Vermont has 17 such distinguished physicians. At the same gathering two physicians were elected to the Society's Fifty Year Club.

The new president of the Vermont State Medical Society is Paul K. French of Burlington, professor of medicine at University of Vermont, College of Medicine.

NEWS
from County Associations

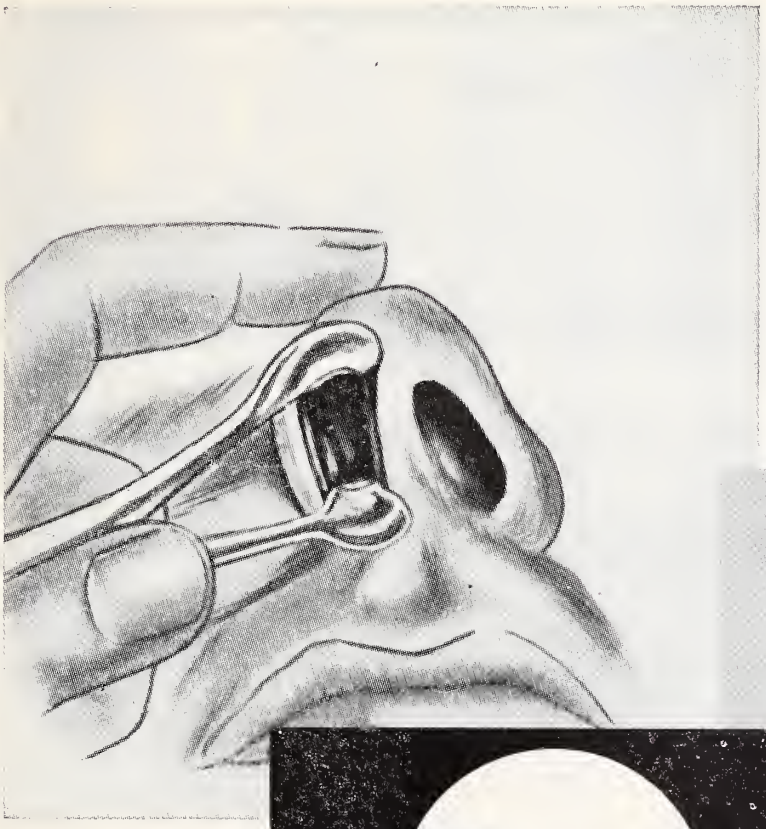
Fairfield

The semi annual meeting of the Fairfield County Medical Association was held at the Wee Burn Country Club in Darien on October 1 with Isaac L. Harshberger presiding. Guests present included the president of the Connecticut State Medical Society, Dr. Edward J. Whalen; the executive secretary of the Connecticut State Medical Society, Dr. Creighton Barker; the Commissioner of Health of the State of Connecticut, Dr. Stanley H. Osborn; and Mr. James G. Burch, public relations director of the Connecticut State Medical Society. Edmund Douglass brought greetings from the New London County Medical Association. Hyman A. Levin represented the New Haven County Medical Association. John O'L. Nolan brought greetings from the Hartford County Medical Association. C. Louis Fincke, councilor, gave a report of the activities of the Council of the State Society and Sidney A. Thompson reported on the activities of the Board of Trustees of the Fairfield County Association. Oliver L. Stringfield reported on the activities of the Infantile Paralysis Medical Advisory Committee to the Fairfield County Chapter of the Infantile Paralysis Foundation. Twenty-three new members were added to the roster of the County Association, having been recommended to membership by the Board of Censors. The number of members in this county is now 725. The by-laws of the Association were amended by appointing the alternate councilor to membership on the Board of Trustees and allowing a five year period for application for membership in the case of applicants separated from the armed forces. Two other changes made it mandatory for members appointed to the Board of Trustees and the House of Delegates of the State Society to have been active members in good standing for at least five years.

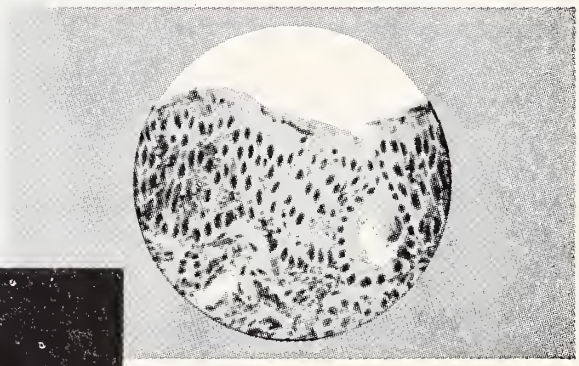
During the afternoon, preceding the business meeting, forty-five members enjoyed the use of the excellent golf course at Wee Burn. In the evening ninety-five members were present at dinner and enjoyed greatly the talk by the Chief of Police of the Greenwich Police Department, John M. Gleason. Mr. Gleason told of his experiences while a representative of the State Department in occupied Germany following World War II.

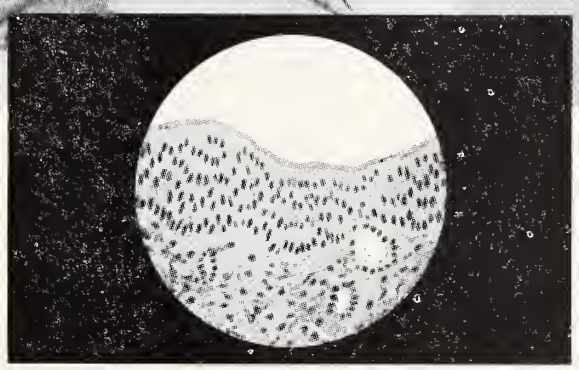
* * * *

The regular meeting of the Bridgeport Medical Association was held at the Algonquin Club in Bridgeport on the evening of October 7 with Mark I. Gildea presiding. The speaker of the evening was John H. Gibbon, Jr., professor of surgery and director of surgical research at the Jefferson Medi-



prompt and prolonged decongestion in **COLDS ...SINUSITIS**





Neo-Synephrine hydrochloride, through immediate and prolonged decongestive action, not only restores nasal patency, but also helps to reestablish and protect the physiologic defense mechanisms of the nasal cavity: sinus drainage and aeration.

Neo-Synephrine hydrochloride is notable for its relative freedom from sting and for virtual absence of compensatory congestion. Furthermore, it does not usually produce systemic side effects such as nervous excitation, cardiac reaction or insomnia.

The decongestive action of Neo-Synephrine hydrochloride is undiminished by repeated use—insuring relief throughout the duration of the illness.

¼% solution (plain and aromatic), 1 oz. bottles
½ and 1% solutions (when stronger vasoconstrictive action is needed), 1 oz. bottles
½% water soluble jelly, ⅝ oz. tubes

Neo-Synephrine®

HYDROCHLORIDE

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U. S. & Canada, brand of phenylephrine

cal College in Philadelphia. Dr. Gibbon spoke on "Carcinoma of the Esophagus." He was introduced by Frank Turchik of Bridgeport.

* * * *

Cornelius J. Shea of Bridgeport entered graduate surgical training at the Medical Center in Jersey City on October 1.

* * * *

The final tournament of the Fairfield County Medical Golf Association was held at the Wee Burn Country Club in Darien on the afternoon of the semi annual meeting of the County Association at which time the team of Rec Davol and John Bolton of Greenwich defeated the team of Paul Harwood and Dutch Wehger of Bridgeport.

* * * *

Wilson G. Scanlon of New Canaan is the author of "Successful Treatment of Hyperhidrosis with Mephobarbital: Report of Two Cases," published in the *Journal A. M. A.*, September 6, 1952.

* * * *

In addition to writing scientific papers and appearing on the programs of such gatherings as the Eighth Annual Congress of the American College of Allergists in Pittsburgh and the First International Congress of Allergists in Zurich, Switzerland, William Kaufman of Bridgeport has been busy writing articles for the lay press. *Scientific Digest*, a pocket size magazine styled after *The Readers Digest*, has published two of these artciles, one in August entitled "The Magical Approach to Health," the other in October headed "Tattooing Could Save Your Life." Both are good and the latter is original, to say the least. *Medical Economics* for October carries one of Dr. Kaufman's products, "Doctors' Wives Are a Problem." The best story from his pen which has come across the editor's desk is one appearing in *Scientific American* for August and entitled "Asthma." Congratulations are in order for a job well done in the difficult field of medical lay writing.

Hartford

A new health education radio series, sponsored by the doctors of Hartford County Medical Association, will be broadcast over radio station WONS on thirteen successive Fridays at 9:15 P. M., beginning November 7. This program called "Doctors Make History," will tell the life story of thirteen historical American physicians and their contributions to community life as well as to medicine. Jim Ameche, famous radio star, will be narrator for the entire series of documentaries.

Dr. Upson, president of the Hartford County Association, said that "Doctors Make History" is not only entertaining but informative as well. He termed the series "an excellent show and one of the very best of its kind." He added that it will point up the contributions to medicine of such doctors as Sir William Osler, Oliver Wendell Holmes, Harvey Cushing, William C. Gorgas, the Mayo Brothers and Benjamin Rush.

"I recommend the program highly because it tells little known facts in the lives of these great men—and their effect on the development of medicine."

The first broadcast told the story of Sir William Osler, the great pathologist, clinician and teacher.

Subsequent broadcasts will be Dr. Oliver Wendell Holmes, November 14; Dr. Harvey Cushing, November 21; Dr. S. Weir Mitchell, November 28; Dr. Charles Norris, December 5; Dr. Nathan Smith Davis I, December 12; Dr. John Evans, December 19; Dr. Irvin Abell, December 26; Dr. Benjamin Rush, January 2; Dr. William Mayo, Sr., Dr. William Mayo, Jr., and Dr. Charles Mayo, January 9; Dr. William C. Gorgas, January 16; Dr. William Henry Welch, January 23; and Dr. William H. Park, January 30.

The entire series is a preparation of the American Medical Association, and transcribed under the supervision of W. W. Bauer, M.D., head of the bureau of health education. The show was produced by Frank Baker with Herbert Foote at the organ. Scripts were prepared by Robert Allison. The thirteen broadcasts are presented as a public service by Hartford County Medical Association in cooperation with radio station WONS of Hartford.

A fifteen minute documentary film called "Your Doctor" was shown to HCMA members at the semi annual meeting at the Chippanee Country Club in Bristol last month. This film was prepared by RKO-Radio Pictures in cooperation with the AMA. It portrays the profession of medicine with compelling realism. "Never before has a film put the medical profession in such a favorable light," says the AMA.

Inaugurating a new policy, HCMA asked new members to be present at the semi annual meeting to be introduced to their officers and associates. Newcomers were asked to stand, give their names, locations and type of practice.

CAMELS

mild and
flavorful!



pack after
pack!

Drs. Paul S. Phelps, director of the Connecticut Tuberculosis Commission; Howard Johnston, medical director of the Bureau of Industrial Hygiene, and Crit Pharris, assistant medical director, United Aircraft Corporation, participated last month in the Tuberculosis Institute for Industrial Nurses at the St. Francis Hospital.

* * * *

Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, gave the commencement address at the 73rd graduation exercises of the Hartford Hospital in September.

* * * *

A mimeographed medical directory containing the names of doctors who will be available to answer press and radio men on health and medical topics has been issued to all newspapers and radio stations in Hartford County. Printed on yellow stock, the directory lists physicians in Hartford, Bristol, Manchester and New Britain.

* * * *

In its October newsletter HCMA issued an attractive pamphlet called "I.L.O. Spells Danger." This pamphlet is a recent publication of the AMA and is a compilation of reprints explaining the menace of the International Labor Organization and what it is trying to do.

* * * *

John O'Leary Nolan, chairman of the HCMA public relations committee, received his Fellowship in the American College of Surgeons last month at their meeting in New York.

* * * *

Louis P. Hastings, head pathologist at St. Francis Hospital, recently celebrated twenty-five years on the staff—his department presented him with a fiberglass fly rod.

* * * *

Theodore W. Steege has resigned as assistant medical director of Hartford Hospital.

* * * *

Paul D. Rosahn, pathologist at the New Britain General Hospital, has been given a leave of absence for a period of one year in order to enable him to accept an appointment in Thailand. There he will teach pathology at the medical school in Bangkok. Dr. Rosahn left for his destination on August 18.

The appointment in Thailand is sponsored by the Mutual Security Agency of the State Department, under contract with Washington University School of Medicine, St. Louis, Missouri. Washington University has appointed Dr. Rosahn an associate professor of pathology, and has assigned him to serve in Thailand for one year as its representative on the faculty of the Medical School located in Bangkok.

* * * *

At the annual meeting of the medical staff of Newington Home for Crippled Children held in October, J. Whitfield Larrabee of Hartford was chosen chairman to succeed Frank Stafford Jones. The other officers elected were Burr H. Curtis, vice-chairman; Sidney R. McPherson, secretary; Frank S. Jones, chief of surgical division; John B. Griggs, chief of medical division; and George Fox, member at large of the executive committee.

* * * *

Ralph M. Filson of Hartford spoke on "The Business of Insurance and the Profession of Medicine" at the annual meeting of the Association of Life Insurance Medical Directors of America held at Los Angeles in October.

Middlesex

Vincent J. Vinci and Alfred N. Sweet attended the Clinical Congress of the American College of Surgeons in New York in the latter part of September.

* * * *

Bertram F. Marks resigned as the health officer of Middletown in order to assume a similar position in Pueblo, Colorado.

* * * *

Herbert Levine took a short course in Cardiac Fluoroscopy at New York Post Graduate School in September.

New Haven

Orvan W. Hess of New Haven is author of "Placenta Previa of the Succenturiate Lobe" published in *American Journal of Obstetrics and Gynecology* for July, 1952.

Table of Contents : December 1952

Critique of Current Theories on the Pathogenesis of Arteriosclerosis
Frederick T. Hatch, M.D., New York City 887

Accuracy of Certain Chemical Determinations in Connecticut Laboratories—The Third Survey
J. G. Snavely, M.D., W. R. C. Golden, PH.D., and Alan B. Cooper, M.A., Stamford 894

Prophylaxis of Rheumatic Fever Daniel F. Levy, M.D., New Haven 899

Internal Drainage in the Treatment of Pseudocysts of the Pancreas
Said H. Tarabishy, M.D., Waterbury 903

Harnessing the Vanishing Dollar Francis T. Fenn, Jr., C.L.U., Hartford 908

Statement of the Present Situation as Regards the Doctors' Draft
Samuel C. Harvey, M.D., New Haven 914

EDITORIALS

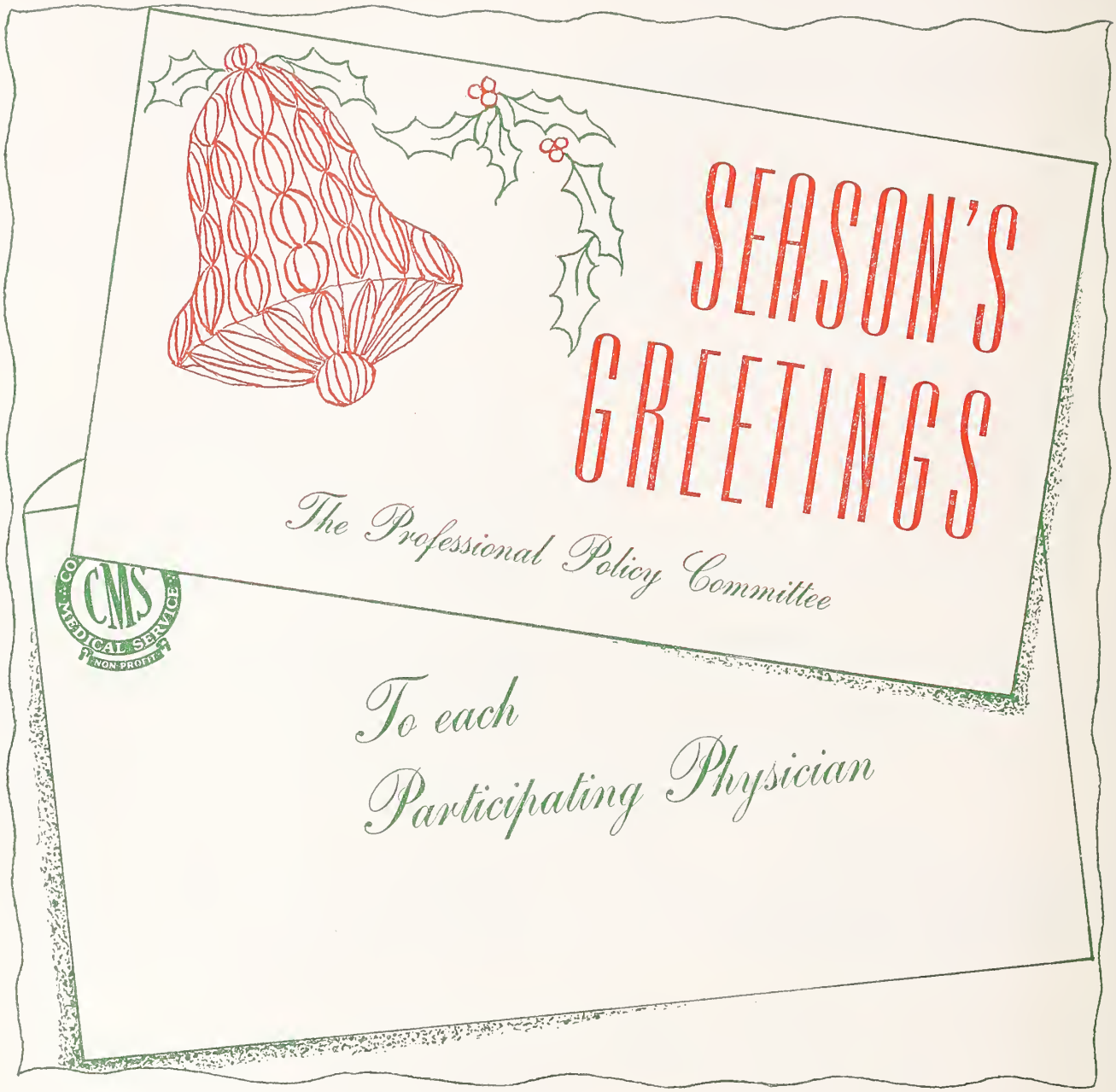
Pledge and Performance 917
The House of Delegates 918
The George M. Smith Book Fund 918
Trinity's New Library 918
It Is Too Easy to be a Member of a Medical Society 918
Participating Physicians in CMS 919
The Lesson of Shangri-La 919

DEPARTMENTS

Progress in Clinical Medicine
Lesion In and About the Second Partition of the Duodenum
N. B. Jaffe, M.D., Bridgeport 923
The President's Page 926
The Secretary's Office 927
The Historian's Note Book
Dr. Mason Fitch Cogswell
Arthur S. Brackett, M.D., Bristol 934
Military Affairs 941
News From Washington 943
Public Relations 947
From Our Exchanges 950
Woman's Auxiliary 952
Our Neighbors 960
News From County Associations 960
News From Yale University School of Medicine 966
New Books in Review 966

MISCELLANEOUS

Remarks of Vernon W. Lippard, M.D. 921
The Doctor's Office 925
Special Notices 956
Index 970



CONNECTICUT CMS MEDICAL SERVICE NON PROFIT

The Blue Shield Plan for Connecticut

CMS IS SPONSORED BY THE CONNECTICUT STATE MEDICAL SOCIETY

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XVI DECEMBER, 1952 No. 12

CRITIQUE OF CURRENT THEORIES ON THE PATHOGENESIS OF ARTERIOSCLEROSIS

FREDERICK T. HATCH, M.D., *New York City*

ONE of my professors in medical school had an interesting method of working out the diagnosis in a clinico-pathological conference. He began with a statement of what he termed the "inescapable facts" of the case. Then he continued with an analysis of the other evidence in the light of those facts. I shall try to follow a similar procedure in discussing with you today the pathogenesis of arteriosclerosis. My remarks will be limited to consideration of the form of arteriosclerosis which is responsible for disability and death. This form, which affects chiefly large arteries and especially the coronary arteries, is now often called atherosclerosis.

There are three facts about the condition which must be considered "inescapable" for they are established beyond doubt: First, the condition occurs to some extent in practically every human being beyond the childhood years. Second, the most constant single finding in arteriosclerotic lesions of all degrees of maturity is the deposition of lipid in and between the cells of the arterial intima. Third, an outstanding characteristic of the condition is the focal distribution of the lesions. Immediately adjacent to a severe lesion may be tissue which appears to be entirely normal.

Four additional statements which might be called "presumptive facts" seem to be helpful to our consideration of the problem. The evidence supporting these statements gives them a slightly lower order of certainty than the "inescapable facts."

First, the lipid found in the lesions is derived more or less directly from the circulating plasma.

Second, a disorder of lipid metabolism exists in some subjects with arteriosclerosis. This is manifested by abnormal lipid or lipoprotein levels in the plasma. The only groups of patients in whom this abnormality has thus far been clearly demonstrated are those with arteriosclerosis of the coronary arteries and those with certain other diseases, notably the nephrotic syndrome.

Third, lesions resembling those found in humans can be produced in several species of experimental animals by inducing a disorder of lipid metabolism in various ways.

Fourth, arteriosclerosis is, at least in part, a reversible process.

Let us now proceed to analyse the current thinking and experimental results of some of the investigators in this field by reconsidering the foregoing statements.

The universal occurrence of the condition[1] raises an important question: Is arteriosclerosis a disease or a sequel of the ageing process? In other words does arteriosclerosis have abnormal mechanical or metabolic causes or is it the inevitable result of the ageing of vascular tissue? Not so long ago the latter idea was prevalent, but current opinion overwhelmingly favors the thesis that arteriosclerosis is a disease.[2] It is difficult to present an absolutely convincing argument that this idea is correct, but certain characteristics of the condition are offered as evidence favorable to that point of view. Thus, arteriosclerosis in advanced and lethal forms is not a rare occurrence in young people without other evidence

Presented at the Connecticut Clinical Congress, New Haven, September 17, 1952

From the Columbia University Research Service, Goldwater Memorial Hospital, and the Department of Medicine, College of Physicians and Surgeons, Columbia University, New York

This study was supported in part by grants from the National Heart Institute, the Albert and Mary Lasker Foundation, and the Public Health Research Institute of the City of New York, Inc.

of ageing of tissues. On the other hand some individuals show little or no arteriosclerosis at a very old age. This is demonstrated in Figure 1 which depicts in cross section the coronary arteries of two individuals aged 33 and 76 years. From study of both human and experimental arteriosclerosis, many pathologists have concluded that the progress of the condition is episodic, that lesions form in crops and not at a uniform rate as ageing processes are believed to proceed.[3] Finally, reversibility of the condition, the evidence for which we shall consider later, seems to be incompatible with the concept of a "normal" ageing process and more characteristic of a disease.

Our second "inescapable fact" is that the most consistent finding in arteriosclerotic lesions is the deposition of lipid material.[1,4] We shall consider at some length how this material reaches its location.

In the first place we can dispose of the possibility that the lipid arose locally. The quantities found are much larger than could have resulted from disintegration of tissues in the site of the lesion.[1] What about local manufacture of the lipid? It is known that practically all tissues can synthesize cholesterol and other lipids from small organic molecules like acetic acid. This has been demonstrated in the rabbit aorta by Chaikoff[5,6] who used isotopically labelled acetic acid. However, it is at present considered unlikely that any tissues other than the liver and perhaps the skin can manufacture quantities as large as those which appear in arteriosclerotic lesions.[7] So much for local origin of the lipid.

MacArthur[8] and others[9-11] have shown that the composition of the lipid material in very early human lesions closely resembles that of plasma. This raises the possibility that plasma lipids penetrate the

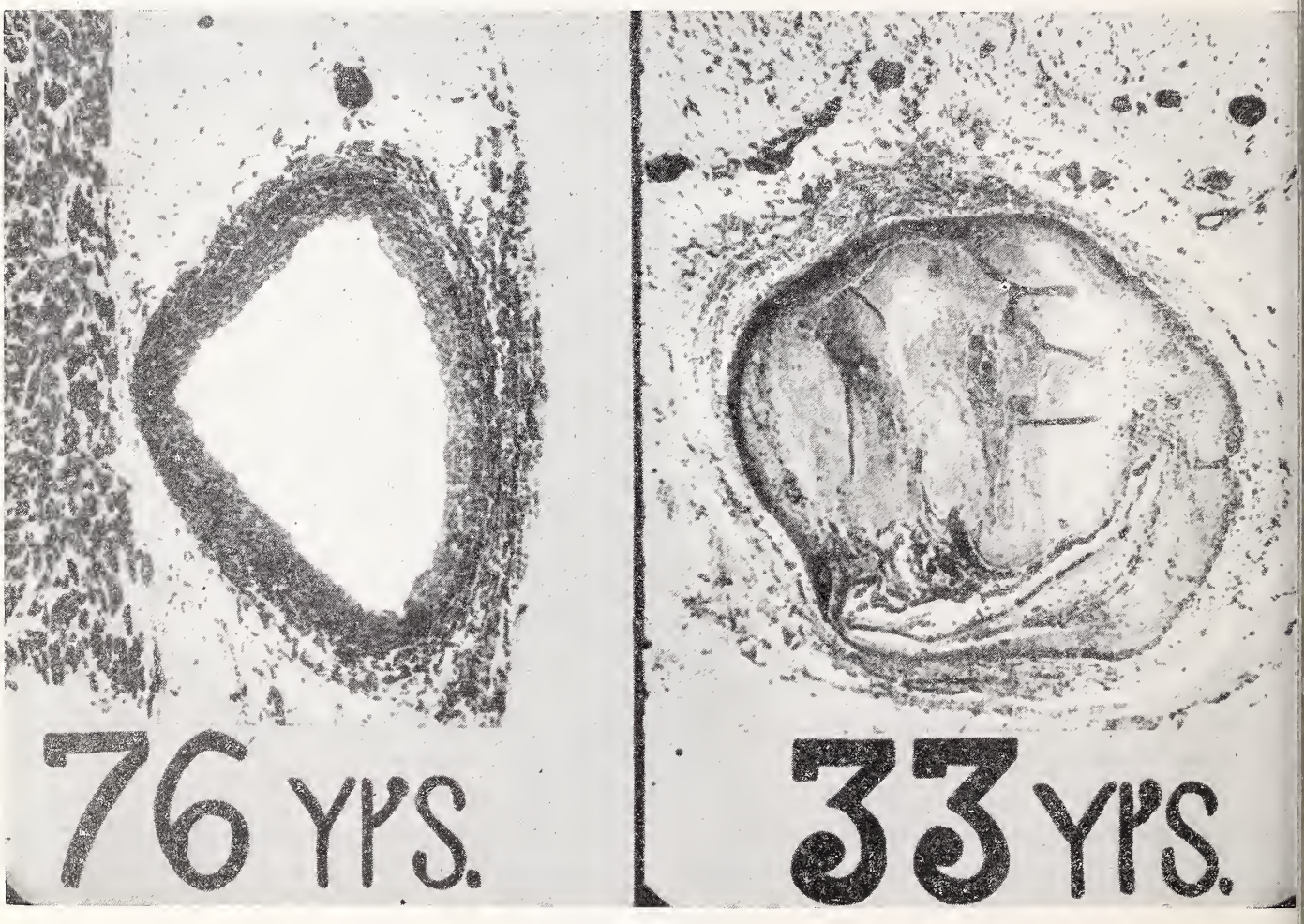


FIGURE 1

Photomicrographs of cross sections of coronary arteries in two patients, aged 33 and 76 years. Occurrence of lethal arteriosclerosis in the younger subject contrasted with absence of condition in the older individual supports thesis that arteriosclerosis is not simply a manifestation of ageing.

vessel wall.[12,13] Biggs and Kritchevsky[14] fed isotopically labelled cholesterol to rabbits in which arteriosclerosis had already been induced. They were able to isolate from the aorta cholesterol which contained the radioactive label. The finding has recently been confirmed in a human subject with advanced arteriosclerosis. This is fairly convincing evidence that plasma lipids have direct access to the vessel wall.

Another approach was taken by Wilens to demonstrate the transfer of lipid from plasma to vessel wall.[15] He perfused segments of surviving human iliac arteries soon after death with plasma under pressures comparable to the human blood pressure. Both by histologic techniques and chemical analyses he found that large amounts of lipid were transferred into the vessel wall. Circumstantial evidence was presented leading to the conclusion that the transfer was not due to postmortem changes. Wilens' work therefore suggests that plasma lipids naturally filter through the blood vessel walls.

Production of a disorder of lipid metabolism in many species of experimental animals is followed by development of vascular lesions resembling human arteriosclerosis. This has been accomplished by feeding cholesterol to guinea pigs,[16] rabbits,[1] chickens,[17,18] dogs,[19] and goats.[20] In some of the species an additional factor was required, such as depression of thyroid function.[19]

It was logical to look for a disorder of the lipids in human plasma as a cause for the deposition of lipids in arteriosclerotic lesions. To do this the concentrations and physicochemical state of the plasma lipids in the individuals who developed the most advanced degrees of arteriosclerosis were compared with those of healthy subjects. Attention may first be called to the obvious abnormalities of the plasma lipids in patients with nephrosis, poorly controlled diabetes mellitus and familial xanthomatosis. All of these groups show accelerated development of arteriosclerosis.

Beginning with the report of Davis, Stern and Lesnick[21] in 1937, a number of investigators have found that milder disorders of the plasma lipid patterns exist in subjects known to have arteriosclerosis of the coronary arteries.[22,23] The abnormality consists of an elevation of plasma cholesterol with an insufficient elevation of plasma phospholipids to keep pace with the normal relationship between the two lipids.[24,25]

Recently the techniques of physical chemistry have been applied fruitfully to elucidation of the physicochemical state of the plasma lipids. It had long been obvious that cholesterol and its esters, neutral fats and even phospholipids could not be simply dissolved in a watery medium like plasma. These substances are large organic molecules which are not soluble in water.

The first lipid-carrying particles identified in the plasma were the chylomicrons. These were found to be large colloidal particles which contain a portion of the plasma neutral fat but only small amounts of the other lipids.[26-28] More recently workers in the laboratory of Dr. E. J. Cohn at Harvard have isolated chemically two species of colloidal molecules containing cholesterol, phospholipids and protein.[29,31] These have been named the alpha and beta lipoproteins. Dr. John Gofman has adapted the ultracentrifuge for study of the rates at which plasma lipoproteins float in a field of centrifugal force.[32-34] He has been able to recognize the alpha and beta lipoproteins and the chylomicrons; and he has also demonstrated a whole spectrum of lipoproteins intermediate between them. Figure 2 describes some of the properties of these colloidal particles and gives their percentage composition of protein and lipids so far as known at the present time.

The alpha and beta lipoproteins are the major lipid-bearing components of normal plasma. To-

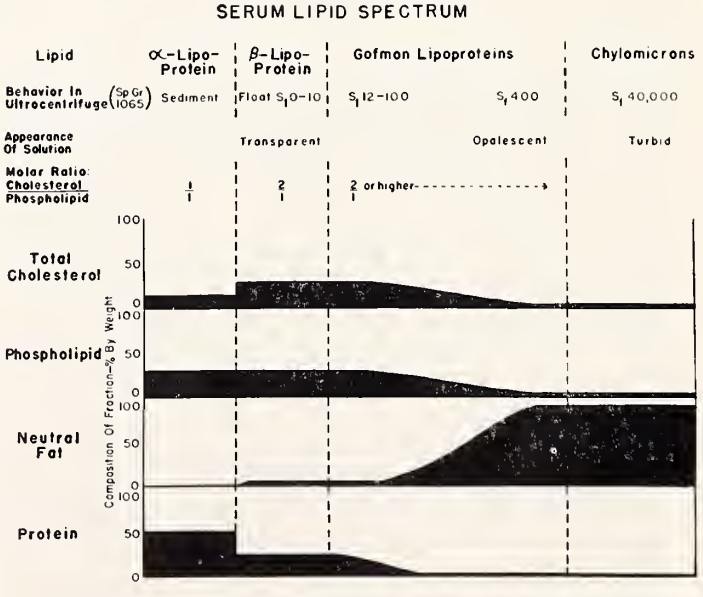


FIGURE 2

Chemical composition and some physical properties of lipid and lipoprotein particles of the plasma. Based on available, incomplete data.

gether they appear to contain at least 90 per cent of the cholesterol and phospholipid which is present. The intermediate lipoproteins found by Gofman and the chylomicrons are present in only small amounts in the plasma of normal animals and man in the fasting state. Ingestion of fat-containing meals produces variable increases in the concentration of these particles. In some individuals, who are now tentatively considered to have an abnormal lipid metabolism, there are sizable levels of the intermediate lipoproteins and chylomicrons present in the plasma even in the postabsorptive state.[34]

Dr. David Barr and Dr. Gofman have applied the Cohn techniques[35,36] and the ultracentrifuge,[34] respectively, to the study of plasma from normal and diseased humans as well as experimental animals. In brief, their results so far are mutually consistent and indicate that in the plasma of humans and animals presumed to have arteriosclerosis there is a lesser proportion of alpha lipoprotein and a greater proportion of either beta lipoprotein or of what I have termed on the slide "the Gofman lipoproteins" than is found in control subjects. Indeed, Gofman has submitted considerable evidence that the presence of specific types of lipoproteins—those in the Sf 12-100 range—correlate closely with the existence of coronary arteriosclerosis. This will require further proof for you must remember that in man one can only compare subjects who are reasonably certain to have arteriosclerosis with so-called "normals," most of whom also have some degree of arteriosclerosis.

Very little is known of the cause of the imbalance in the plasma lipoprotein spectrum of human subjects with coronary arteriosclerosis. Many statistical studies conducted in different geographic areas suggest that high dietary intakes of fat and cholesterol or calories may be etiologic factors.[37-44] However, controlled observations in man show that the plasma lipids are not readily affected by reasonable variations in total fat intake or by extreme changes in cholesterol intake.[45-49] Sharp restriction of the dietary fat below 30 or 40 Gm. per day does produce changes in the plasma lipid levels.[42,49-52] These changes are highly variable from one individual to another: In many instances the cholesterol level is substantially reduced; in others the phospholipid and neutral fat concentrations are markedly elevated. But in general it is not possible to reduce the level of any plasma lipid below the normal range by use of a restrictive diet. It seems likely that some other explanation rather than that of dietary variation will ultimately be found for the geographical differences in the incidence of arteriosclerosis.[53]

Recent work from Gofman's laboratory[54] and from the National Heart Institute[55] has disclosed the existence of a system in the body which seems to be concerned with maintenance of proper relationships between the amounts of the alpha and the beta lipoproteins and with prevention of excessive amounts of particles in the range of the Gofman lipoproteins. The system involves heparin or heparin-like substances among other components. This is an interesting development but it still is not known whether the system is defective in those who develop arteriosclerosis.

Work in progress in Barr's laboratory reveals that estrogens, at least in large doses, are capable of improving the abnormal relationship between the alpha and the beta lipoproteins in the plasma of human patients with coronary arteriosclerosis.[56]

Katz and his associates have recently shown preventive and curative effects of estrogens upon experimental arteriosclerosis in the coronary arteries of chicks, although the lesions in the aorta were not affected.[57] Again it is too early to translate the conclusions from these studies into clinical medicine.

We have already discussed the fairly definite evidence that the colloidal state of the plasma lipids is unbalanced in some humans and animals with arteriosclerosis. If this abnormal mixture of lipoproteins is constantly filtered into the walls of blood vessels we should not be surprised if an excessive amount were deposited there. However, we must consider another aspect of the transport of lipoproteins across vessel walls; namely, the rate and mechanism by which the lipids are removed, for these factors may also be important.

The reversibility of the arteriosclerotic process, which I stated as a "presumptive fact," indicates that lipid, once deposited, can be removed from the area at a later time. Incidentally this reversibility provides us with our greatest ray of hope that a cure for the disease can be found. The evidence for reversibility comes from several directions. So-called "fatty streaks" are intimal deposits of lipid found in infancy and childhood.[1,58-60] Many pathologists believe that these deposits are closely comparable in origin and in structure to arteriosclerotic lesions. Yet it is thought that some of them disappear later

in life. Wilens[61] has submitted evidence that when severe malnutrition and wasting occurs in humans before death the arteriosclerotic lesions found at autopsy are flatter and contain less lipid than those observed in well nourished individuals of the same age. The presumption is that the lesions decreased in size during the terminal period of wasting. Finally, experimentally produced lesions in animals unquestionably do regress to some degree when the causative stimulus is discontinued.[62,63]

The mechanism of removal of lipid material from vascular tissue is not understood. Kellner[64,65] has demonstrated substantial amounts of lipid returning in the lymph from the hind leg of rabbits. Some or even all of the lipid entering the vessel wall may normally be removed by lymphatic drainage. However, we now realize that none of the lipids found in plasma and in arteriosclerotic lesions is metabolically inert. All body tissues appear to be able to synthesize and probably to break down each type of lipid.[66] Therefore local metabolic breakdown may also play a role in the removal of lipids from the vessel wall. Such degradative reactions are perhaps impaired under some circumstances.

We come now to our third "inescapable fact," the focal nature of the disease. Wolbach referred to this as "The vagaries of distribution of arteriosclerosis." These vagaries have proven to be the greatest "stumbling block" to the development of a coherent theory of the pathogenesis of arteriosclerosis. They have even caused some investigators to deny that lipid metabolism has anything to do with the disease. For what right has a metabolic disorder to strike one area and spare another within a single tissue! We must immediately admit other factors to our theory of pathogenesis, factors which tend to localize the abnormal process in certain regions.

A host of such factors has been suggested:[1,13,67]

1. The blood pressure of a given region in the vascular tree is one. Hypertension aggravates arteriosclerosis in humans[68] and also in dogs fed cholesterol and thiouracil.[69] Arteriosclerosis is not severe in the pulmonary arteries unless the blood pressure there is elevated.[70] The added gravitational pressure load on the lower trunk and legs which results from man's erect stance is believed to be responsible for the severity of arteriosclerosis in those areas.

2. Dr. William Dock has presented a strong argument for the importance of areas of thickened intima as sites of predilection for arteriosclerotic lesions.[67] A certain amount of intimal thickening apparently occurs in everyone, and this is especially prominent in the coronary arteries and in other areas where lesions of arteriosclerosis are commonly seen.

3. On the other hand Lansing believes that arteriosclerosis occurs only at sites overlying degenerative changes in the media of the vessel wall.[71,72]

4. Interference with the blood supply to the vessel wall through the vasa vasorum undoubtedly occurs in luetic aortitis and when venous tissue is grafted in place of arterial segments. These situations are also accompanied by the development of arteriosclerosis in the affected areas.

5. From the laboratory, evidence has come that local freezing[73] or cauterization[74] of a portion of the vessel wall will be followed by development of arteriosclerotic lesions in the damaged area if a disorder of lipid metabolism is also produced.

6. Here in New Haven Drs. de Suto-Nagy, Waters and McAllister have combined general and local factors in very interesting experiments. They observed that injections of allyl amine in dogs produced inflammatory vascular lesions in the coronary arteries and in some fat depots.[75] A necrotizing arteritis occcurred with ultimate fibrosis of the intimal and medial layers, but little or no lipid was deposited. The investigators then superimposed a disorder of the plasma lipids, either by giving fat emulsions intravenously[76] or by injecting a detergent, Triton, which causes large increases in the plasma lipid levels.[77,78] Animals treated with the combined technique of producing local vascular damage and elevated plasma lipid levels showed lesions of the coronary arteries which contained lipid and bore considerable resemblance to human atheromata.

It is apparent that injury to the vessel wall is an important factor in determining the location of lesions in experimental studies and occasionally in clinical experience. But what the local factors are in the vast majority of human cases of arteriosclerosis is by no means clear. Study of the physiology and metabolism of individual cells by use of tissue cultures[79,80] or similar techniques may be required to obtain this important information.

CONCLUSION

We have considered the experimental results and theories of some of the investigators actively attacking the problem of arteriosclerosis. The evidence has been analyzed in the light of three facts designated

as "inescapable" and four other statements designated as presumably established.

Although the condition is of almost universal occurrence in man the consensus now is that arteriosclerosis is a disease and not solely an expression of the ageing process.

The pathogenesis of arteriosclerosis seems to be closely related to the accumulation of lipid in the lesions. The evidence is becoming strong that plasma colloidal lipoproteins are naturally filtered through the blood vessel wall. Deposition of lipids there is probably brought about either by an imbalance among the various species of plasma lipoproteins or by failure of the processes which ordinarily remove the filtered lipoprotein mixture. Available data indicate that there are abnormal patterns of lipids and lipoproteins in the plasma of humans and experimental animals with arteriosclerosis. Derangement of the removal functions has not so far been demonstrated.

Finally, in order to avoid conflict with the "inescapable fact" that arteriosclerosis has a focal distribution, local factors affecting some cells and not others in the arterial intima must be added to the metabolic causes. Experimental analysis of these local factors is proving to be extremely difficult.

We have covered much ground in the past hour but necessarily have omitted many observations and theories. I hope in the main to have shown you how the techniques and efforts of the biochemist and physical chemist have broadened the more venerable approaches of the experimental pathologist and the clinical observer. The additions to our knowledge of arteriosclerosis which have resulted from the comparatively recent application of these newer disciplines to the problem give us great cause for optimism about the future.

The author wishes to acknowledge the valuable tutelage of Professor F. E. Kendall of Columbia University.

BIBLIOGRAPHY

1. Duff, G. L., and McMillan, G. C.: Pathology of Atherosclerosis. Am. J. Med., 11:92-108, 1951.

2. Transactions of the Fifth Conference on Factors Regulating Blood Pressure. Josiah Macy, Jr. Foundation, New York, 1951.

3. Holman, R. L.: Does Arteriosclerosis Develop by Episodic Stages? Am. Heart J., 38:469, 1949.

4. Combined Staff Clinics: Cholesterol Metabolism and Arteriosclerosis. Am. J. Med., 6:103-124, 1949.

5. Chernick, S., Srere, P. A., and Chaikoff, I. L.: The Metabolism of Arterial Tissue. II. Lipide Synthesis: The Formation in vitro of Fatty Acids and Phospholipids by Rat Artery with C^{14} and P^{32} as Indicators. J. Biol. Chem., 179:113-118, 1949.

6. Siperstein, M. D., Chaikoff, I. L., and Chernick, S. S.: Significance of Endogenous Cholesterol in Arteriosclerosis: Synthesis in Arterial Tissue. Science, 113:747-749, 1951.

7. Srere, P. A., Chaikoff, I. L., Treatman, S. S., and Burstein, L. S.: The Extrahepatic Synthesis of Cholesterol. J. Biol. Chem., 182:629-634, 1950.

8. McArthur, C. S.: The Acetone Soluble Lipid of the Atheromatous Aorta. Biochem. J., 36:559-570, 1942.

9. Weinhouse, S., and Hirsch, E. F.: Chemistry of Atherosclerosis. I. Lipid and Calcium Content of the Intima and of the Media of the Aorta with and without Atherosclerosis. Arch. Path., 29:31-41, 1940.

10. Weinhouse, S., and Hirsch, E. F.: Atherosclerosis II. The Lipids of the Serum and Tissues in Experimental Atherosclerosis of Rabbits. Arch. Path., 30:856-867, 1940.

11. Buck, R. C., and Rossiter, R. J.: Lipids of Normal and Atherosclerotic Aortas: A Chemical Study. Arch. Path., 51:224-237, 1951.

12. Anitschkow, N.: Zur Histophysiologie der Arterienwand. Klin. Wchnschr., 4:2233-2235, 1925.

13. Gubner, R., and Ungerleider, H. E.: Arteriosclerosis. A Statement of the Problem. Am. J. Med., 6:60-83, 1949.

14. Biggs, M. W., and Kritchevsky, D.: Observations with Radioactive Hydrogen (H^3) in Experimental Atherosclerosis. Circulation, 4:34-42, 1951.

15. Wilens, S. L., The Experimental Production of Lipid Deposition in Excised Arteries. Science, 114:389-393, 1951.

16. Anitschkow, N.: Uber die Experimentelle Atherosclerose der Aorta beim Meerschweinchen. Beitr. z. path. Anat. u. z. allg. Path. 70:265-281, 1922.

17. Katz, L. N.: Studies on Experimental Atherosclerosis and Hypertension. Ref. 2, p. 174.

18. Katz, L. N.: Experimental Atherosclerosis. Circulation, 5:101-114, 1952.

19. Steiner, A., Kendall, F. E., and Bevans, M.: Production of Arteriosclerosis in Dogs by Cholesterol and Thiouracil Feeding. Am. Heart J., 38:34-42, 1949.

20. Chalatow, S. S.: Bemerkungen zu den Arbeiten über die experimentelle Cholesterinkrankheit des Kaninchens und anderer Tiere. Virchow's Arch. f. Path. Anat., 272:691-708, 1929.

21. Davis, D., Stern, B., and Lesnick, G.: The Lipid and Cholesterol Content of the Blood of Patients with Angina Pectoris and Arteriosclerosis. Ann. Int. Med., 11:354-369, 1937.

22. Gertler, M. M., Garn, S. M., and Lerman, J.: The Interrelationships of Serum Cholesterol, Cholesterol Esters and Phospholipids in Health and in Coronary Artery Disease. Circulation, 2:205-214, 1950.

23. Steiner, A., Kendall, F. E., and Mathers, J. A. L.: Abnormal Serum Lipid Pattern in Patients with Coronary Arteriosclerosis. Circulation 5:605-608, 1952.

24. Peters, J. P., and Man, E. B.: The Interrelations of

Serum Lipids in Normal Persons. J. Clin. Investigation, 22:707-714, 1943.

25. Albrink, M. J., Man, E. B., and Peters, J. P.: Serum Lipids in Infectious Hepatitis and Obstructive Jaundice. J. Clin. Investigation, 29:781-788, 1950.

26. Gage, S. H., and Fish, P. A.: Fat Digestion, Absorption and Assimilation in Man and Animals as Determined by the Dark Field Microscope and a Fat-soluble Dye. Am. J. Anat., 34:1, 1924.

27. Elkes, J. J., Frazer, A. C., and Stewart, H. C.: The Composition of Particles Seen in Normal Human Blood under Darkground Illumination. J. Physiol., 95:68-82, 1939.

28. Frazer, A. C.: Fat Absorption and its Relationship to Fat Metabolism. Physiol. Rev., 20:561-581, 1940.

29. Oncley, J. L., Gurd, F. R. N., and Melin, M.: Preparation and Properties of Serum and Plasma Proteins. XXV. Composition and Properties of Human Serum beta-Lipoprotein. J. Am. Chem. Soc., 72:458-464, 1950.

30. Cohn, E. J. et al: A System for the Separation of the Components of Human Blood: Quantitative Procedures for the Separation of the Protein Components of Human Plasma. J. Am. Chem. Soc., 72:465-474, 1950.

31. Lever, W. F., Gurd, F. R. N., Uroma, E., Brown, R. K., Barnes, B. A., Schmid, K, and Schultz, E. L.: Chemical, Clinical, and Immunological Studies on the Products of Human Plasma Fractionation. XL. Quantitative Separation and Determination of the Protein Components in Small Amounts of Normal Human Plasma. J. Clin. Investigation, 30:99-111, 1951.

32. Gofman, J. W., Lindgren, F. T., and Elliot, H.: Ultracentrifugal Studies of Lipoproteins of Human Serum. J. Biol. Chem., 179:973-979, 1949.

33. Gofman, J. W., Lindgren, F., Elliot, H., Mantz, W., Hewitt, J., Strisower, B., and Herring, V.: The Role of Lipids and Lipoproteins in Atherosclerosis. Science, 111:166-171 and 186, 1950.

34. Jones, H. B., Gofman, J. W., Lindgren, F. T., Lyon, T. P., Graham, D. M., Strisower, B., and Nichols, A. V.: Lipoproteins in Atherosclerosis. Am. J. Med., 11:358-380, 1951.

35. Russ, E. M., Eder, H. A., and Barr, D. P.: Protein-lipid Relationships in Human Plasma. I. In Normal Individuals. Am. J. Med., 11:468-479, 1951.

36. Barr, D. P., Russ, E. M., and Eder, H. A.: Protein-lipid Relationships in Human Plasma. II. In Atherosclerosis and Related Conditions. Am. J. Med., 11:480-493, 1951.

37. Oppenheim, F.: Review of 100 Autopsies of Shanghai Chinese. China Med. J., 39:1067-1076, 1925.

38. Willius, F. A., Smith, H. L., and Sprague, P. H.: A Study of Coronary and Aortic Sclerosis: Incidence and Degree in 5060 Consecutive Postmortem Examinations. Proc. Staff Meet., Mayo Clin., 8:140-144, 1933.

39. Rosenthal, S. R.: Studies in Atherosclerosis: Chemical, Experimental and Morphologic. I and II. Arch. Path. 18:473-506, 1934.

40. Snapper, I.: Chinese Lessons to Western Medicine, Page 160. Interscience Publishers, Inc., New York, 1941.

41. Steiner, P. E.: Necropsies on Okinawans. Arch. Path., 42:359-380, 1946.

42. Davidson, J. D.: Diet and Lipotropic Agents in Arteriosclerosis. Am. J. Med., 11:736-748, 1951.

43. Dedichen, J., Ström, A., Adelsten-Jensen, R., and Closs, K.: Incidence of Atherosclerotic Disease During War Years. Ref. 2, p. 117.

44. Cornell Conference on Therapy: Low Cholesterol Diet in the Treatment of Atherosclerosis. Am. J. Med., 12:357-365, 1952.

45. Keys, A., with collaboration of Mickelson, O., Miller, E., and Chapman, C. B.: The Relation in Man between Cholesterol Levels in the Diet and in the Blood. Science, 112:79-81, 1950.

46. Wilkinson, C. F., Jr., Blecha, E., and Reimer, A.: Is There a Relation Between Diet and Blood Cholesterol? Arch. Int. Med., 85:389-397, 1950.

47. Gertler, M., Garn, S. M., and White, P. D.: Diet, Serum Cholesterol and Coronary Artery Disease. Circulation, 2:696-704, 1950.

48. Moses, C., Rhodes, G. L., Leatham, E., and George, R. S.: Effect of Cholesterol Feeding during Pregnancy on Blood Cholesterol Levels and Placental Vascular Lesions. Circulation, 6:103-105, 1952.

49. Hatch, F. T., and Kendall, F. E.: Effects of Restriction of Dietary Fat and Cholesterol upon Serum Lipids and Lipoproteins in Patients with Hyptertension. To be published.

50. Starke, H.: Effect of the Rice Diet on the Serum Cholesterol Fractions of 154 Patients with Hypertensive Vascular Disease. Am. J. Med., 9:494-499, 1950.

51. Hildreth, E. A., Mellinkoff, S. M., Blair, G. E., and Hildreth, D. M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration. Circulation, 3:641-646, 1951.

52. Keys, A.: Human Atherosclerosis and the Diet. Circulation, 5:115-118, 1952.

53. Collumbine, H.: Cardiovascular Disease in Ceylon. Ref. 2, p. 124.

54. Graham, D. M., Lyon, T. P., Gofman, J. W., Jones, H. B., Yankley, A., Simonton, J., and White, S.: Blood Lipids and Human Atherosclerosis. II. The Influence of Heparin upon Lipoprotein Metabolism. Circulation, 4:666-673, 1951.

55. Anfinsen, C. B., Boyle, E., and Brown, R. K.: The Role of Heparin in Lipoprotein Metabolism. Science, 115:583-586, 1952.

56. Barr, D. P., Russ, E. M., and Eder, H. A.: The Influence of Estrogens on Lipoproteins in Atherosclerosis. To be published, Vol. 65, Transactions of the Association of American Physicians. Dornan, Philadelphia, 1952.

57. Pick, R., Stamler, J., Rodbard, S., and Katz, L. N.: The Inhibition of Coronary Atherosclerosis by Estrogens in Cholesterol-Fed Chicks. Circulation, 6:276-280, 1952.

58. Aschoff, L.: Lectures on Pathology. Paul B. Hober, Inc., New York, 1924.

59. Ophüls, W.: The Pathogensis of Arteriosclerosis in:

Cowdry, E. V., Arteriosclerosis. The Macmillan Co., New York, 1933, p. 249 ff.

60. Hueper, W. C.: Arteriosclerosis. Arch. Path., 39:187-216, 1945.

61. Wilens, S. L.: The Resorption of Arterial Atheromatous Deposits in Wasting Disease. Am. J. Path., 23:793-804, 1947.

62. Horlick, L., and Katz, L. N.: Retrogression of Atherosclerotic Lesions on Cessation of Cholesterol Feeding in the Chick. J. Lab. and Clin. Med., 34:1427-1442, 1949.

63. Bevans, M., Davidson, J. D., and Kendall, F. E.: Regression of Lesions in Canine Arteriosclerosis. Arch. Path., 51:288-292, 1951.

64. Kellner, A., and Chang, D. C.: The Lipid Composition of Tissue Lymph in Normal and in Hyperlipemic Rabbits. Circulation, 2:465-466, 1950.

65. Kellner, A., and Chang, D. C. D.: Studies of the Permeability of the Endothelium to Lipids in Relation to Atherosclerosis. Am. J. Path., 27:682-684, 1951.

66. Gould, R. G.: Lipid Metabolism and Atherosclerosis. Am. J. Med., 11:209-227, 1951.

67. Dock, W.: Blood Flow, Blood Pressure and Intimal Thickness as Factors in Localizing Atheroma Formation. Ref. 2, p. 129.

68. Faber, M., and Lund, F.: The Human Aorta. Influence of Obesity on the Development of Arteriosclerosis in the Human Aorta. Arch. Path., 48:351-361, 1949.

69. Wakerlin, G. E., Moss, W. G., Neville, J. B., and Bourque, J. E.: Effect of Experimental Renal Hypertension on Experimental Cholesterol Atherosclerosis. Ref. 2, p. 193.

70. Moschcowitz, E.: Vascular Sclerosis with Special Reference to Arteriosclerosis. Oxford University Press, New York, 1942, p. 15.

71. Lansing, A. I.: Changes in the Media in Human Arteriosclerosis and Hypertension. Ref. 2, p. 140.

72. Lansing, A. I.: The Role of Elastic Tissue in the Formation of the Arteriosclerotic Lesion. Ann. Int. Med., 36:39-49, 1952.

73. Kelly, F. B., Taylor, C. B., and Hass, G. M.: Experimental Atheroarteriosclerosis. Localization of Lipids in Experimental Arterial Lesions of Rabbits with Hypercholesterolemia. Arch. Path., 53:419-436, 1952.

74. Schlichter, J. G., Katz, L. N., and Meyer, J.: The Occurrence of Atheromatous Lesions after Cauterization of the Aorta Followed by Cholesterol Administration. Am. J. Med. Sci., 218:603-609, 1949.

75. Waters, L. L.: Changes in the Coronary Arteries of the Dog Following Injections of Allylamine. Am. Heart J., 35:212-220, 1948.

76. McAllister, W. B., and Waters, L. L.: The Localization of Particulate Fat in Injured Blood Vessels. Tr. New York Acad. Sci., 14:83, December 1951.

77. Kellner, A., Correll, J. W., and Ladd, A. T.: Sustained Hyperlipemia Induced in Rabbits by Means of Intravenously Injected Surface-Active Agents. J. Exp. Med, 93:373-383, 1951.

78. de Suto-Nagy, G. I., and Waters, L. L.: The Effect of Altered Lipid Metabolism on Experimental Lesions of the Coronary Arteries. Circulation, 4:468, 1951.

79. Simms, H. S., and Stillman, N. P.: Substances Affecting Adult Tissue in vitro; Stimulating Action of Trypsin on Fresh Adult Tissue. J. Gen. Physiol., 20:603-619, 1937.

80. Simms, H. S.: The Regulation of Fat Deposition by the Lipfanogens and Antilipfanogens. Ref. 2, p. 76.

THE ACCURACY OF CERTAIN CHEMICAL DETERMINATIONS IN CONNECTICUT LABORATORIES — THE THIRD SURVEY

J. G. Snavely, M.D., W. R. C. Golden, PH.D., and Alan B. Cooper, M.A., *Stamford*

Two previous surveys of the accuracy of certain common chemical determinations in clinical laboratories of Connecticut have been reported by Snavely and Golden.[1,2] Both showed unsatisfactory levels of accuracy. The present study is concerned with similar determinations but differs from the previous two in that data regarding training and experience of personnel and specific analytical methods was obtained. In addition, anonymity was eliminated. The participants were assured that no publicity would be made of the individual results.

HANDLING OF INDIVIDUAL REPORTS

All individual report sheets were coded by number, so that once the data had been extracted from the individual reports, no personal identification remained on the working data. One of us (A. B. C.) who was not acquainted with any participant was responsible for the extraction of data.

TEST MATERIALS

The unknowns submitted to participants by special delivery mail included glucose, urea, sodium chloride and human plasma (for total pro-

From the Department of Laboratories, The Stamford Hospital, Stamford, Connecticut

tein), each in 2 different concentrations. To our knowledge, samples reached participants over night. The stability of the test materials was checked in the reference laboratory by performing analyses on different samples over a period of two weeks during which time the test materials were exposed to room temperature for considerable periods. No evidence of deterioration could be demonstrated. Table I gives the substances, concentrations, allowed limits of error and preparation notes.

Table I

Values of Unknowns

DETERMINATION	CORRECT VALUE	ALLOWED ERROR
Nitrogen[1]	Sample (3)—25 mg/100 ml	± 3 mg/100 ml
	Sample (4)—60 mg/100 ml	± 6 mg/100 ml
Chloride[2]	Sample (5)—85 meq/1	± 4 meq/1
	Sample (6)—105 meq/1	± 5 meq/1
Protein[3]	Sample (7)—7 gm/100 ml	± 0.7 gm/100 ml
	Sample (8)—5 gm/100 ml	± 0.5 gm/100 ml

[1](NPN or BUN) A weighed amount of Urea, C.P. in acetate buffer.

[2]A weighed amount of NACL, C.P., in distilled water.

[3]Pooled normal human plasma (total protein nitrogen determined by Macro-Kjeldahl technique).

PARTICIPATION IN THIS STUDY

Fifty-one laboratories participated. Of these, 34 were situated in hospitals and 17 were private commercial laboratories. This number was nine greater than the previous number of participants and represented most of the active clinical laboratories of the State. The hospital group was somewhat more representative, since a larger percentage of these laboratories participated.

RESULTS

For technical reasons glucose had to be eliminated from consideration in tabulating the results.* The tabulated results include six determinations: two of urea, 2 of sodium chloride and two of plasma protein. Only the laboratories reporting all unknowns are considered. Table II gives the results divided between hospital and nonhospital laboratories. These results show a small difference between these groups. It is not possible to state whether this difference is significant. The percentage of errors (35.2 per cent) of all participants appears significantly less than that found in the results of survey II (48 per cent).

*Since the glucose unknowns were aqueous solutions it was intended, although not expressly stated, that 1:10 dilutions were to be made with water. Some laboratories used routine protein-precipitating reagents (sulfuric acid—sodium tungstate) for this purpose. The excess of tungstate produces higher than expected values with certain sugar methods.

Table II

Table of Errors—By Laboratories

GROUP	NO. OF LABORATORIES	NO. OF TESTS PERFORMED	NO. OF OF ERRORS*	PERCENTAGE OF ERRORS
Hospital laboratories	34	202	66	32.6
Private commercial laboratories	17	96	39	40.6
All laboratories	51	298	105	35.2

*Errors are defined as values reported outside the allowed limits Table I).

Table III shows the number of determinations reported correctly according to type of laboratory. In the hospital laboratory group 49 per cent of participants reported five or six out of six unknowns correctly. In the private commercial laboratory group only 29 per cent of participants had similar results. The private commercial laboratories predominated in the group reporting three or four correct results out of six, but an equal percentage of private commercial and hospital laboratories were in the group reporting only one or two correct results out of six.

Table III

Grouping of Laboratories by Number of Correct Results

Number of correct results	6	5	4	3	2	1	Total
Number of hospital laboratories	6	10	8	2	4	3	33
Number of private laboratories	1	3	2	5	2	1	14
Total laboratories	7	13	10	7	6	4	47

Note: One hospital and 3 private laboratories are omitted because all six determinations were not done.

Table IV shows the percentage of errors by determination. The composite average errors for most determinations are of the same order of magnitude (6.6-13.6 per cent).†

†Composite average error is defined as: $\frac{\Sigma \Delta}{N}$, where Δ is deviation expressed as per cent of the expected value and N is the number of observations.

Table IV

Table of Errors by Determination—All Laboratories

Determination	Correct Value	Composite Average Error (per cent)	Range of Values Reported	Per Cent Incorrect
Nitrogen				
Sample 3	25	13.6	16-50	33
Sample 4	60	9.3	32-89	41
Chloride				
Sample 5	85	8.8	62-141	45
Sample 6	105	9.0	60-169	47
Protein				
Sample 7	7.0	7.8	3.8-8.7	26
Sample 8	5.0	6.6	3.5-6.2	20

The protein samples were both reported with the smallest composite average errors (6.6-7.8 per cent). Examination of the column "range of values reported" shows some widely aberrant results from individual laboratories and a wide spread between the lowest and highest results. The per cent of laboratories reporting incorrect results ranged from 20 per cent (protein sample 5.0 Gm. per 100 ml.) to 47 per cent (chloride value 105 meq/liter).

Table V gives the composite average error for the different chloride methods reported. Fortuitously an approximately equal number of laboratories reported the four methods given. The superiority of the results obtained by the Sendroy Method as modified by Van Slyke and Hiller[3] is apparent and requires no statistical proof.

Table V

Relative Accuracy of Four Chloride Methods

Method	Van Slyke-Hiller[1]	Schales and Schales[2]	Sendroy (colorometric)[3]	Whitehorn[4]
Composite average error (per cent)	1.8	2.9	7.7	18.6
Per cent of determinations correct	85	79	56	20

Many individual variations and modifications of a published method were used. Therefore the references below are intended to designate only the general procedures.

[1]Reference No. 3, bibliography.

[2]Schales, O., and Schales, S.: J. Biol. Chem. 140, 879-84 (1941).

[3]Sendroy, J.: J. Biol. Chem. 120, 419-39 (1937).

[4]Whitehorn, J. C.: J. Biol. Chem. 45, 449-60 (1921).

Similar division was made of the reported protein methods and these results are given in Table VI. The differences between the biuret method and the remaining methods were checked by the Chi-square method and found to be significant. The apparent superiority of this method as far as these results are concerned is therefore not due to chance.

Table VI

Relative Accuracy of Three Protein Methods

Method	Biuret[1]	Greenberg[2]	Digestion and Direct Nesslerization[3]
Composite average error (per cent)	3.2	5.2	9.4
Per cent of determinations correct	97	83	67

See footnote to Table V.

[1]Gornall, A. G., Bardawill, C. J., and David, M. M.: J. Biol. Chem. 177, 751-66 (1949), Weichselbaum, T. E.: Am. J. Clin. Path-Tech Suppl 10, 40-48 (1946).

[2]Greenberg, D. M.: J. Biol. Chem. 82, 545-50 (1929).

[3]Hawk, P. B., Oser, B. L., Summerson, W. H.: Practical Physiological Chemistry—ed. 12, Philadelphia. P. Blakiston's Son & Co., 1947, p. 547.

Table VII summarizes the personnel data derived from the returns of laboratories showing the ten most accurate and ten least accurate sets of results. These groups will be referred to below as the upper 10 and lower 10 groups, respectively. Two methods were used to obtain this classification.

The simple method of listing the laboratories in the order of number of determinations right was tried first. Following this, the laboratories were independently listed in the order of increasing size of the composite average error for all determinations. The positions of the laboratories in both lists were insignificantly different and the upper 10 or lower 10 were the same in both lists.

It is immediately apparent from Table VII that a profound difference exists between the sets of personnel of the upper 10 and lower 10 groups. In the upper 10 group the average experience of the calibrator (or person setting up the method) was seven years, with only one person reporting less than one year of experience. By contrast the lower 10 group shows an average experience record of three years with seven laboratories reporting that the person in charge of calibration (or setting up a method) had less than one year of actual experience. The analysts

Table VII

Ten Laboratories With Worst Results

Number correct results of 6 unknowns	Composite average error (per cent)	Degree and years experience[1] Calibrator	Degree and years experience[1] Analyst	Title and degree of person in charge of laboratory
2	9.3	10	10	Director
2	9.7	M.D. 0	0	Pathologist B.S. M.D.
2	12.5	B.S. (M.T.)[2] 0	B.S. (M.T.)[2] 0	Pathologist[3] B.S. M.D.
2	15.4	B.S. (M.T.)[2] 0	B.A. (M.T.)[2] 0	Technician B.S.
2	16.7	B.A. 10	B.A. 10	Pathologist[3] B.S. M.D.
2	18.7	Less than 1	B.S. less than 1	Co-owner B.S.
1	12.7	B.S. (M.T.)[2] 0	0	Technician B.S.
1	12.9	B.S. (M.T.)[2] 3	B.A. (M.T.)[2] less than 1	Pathologist[3] B.S. M.D.
1	16.7	B.S. less than 1	Less than 1	Pathologist[3] B.S. M.D.
1	39.4	PH.G. 5	PH.G. 5	Director B.S.
Average	16.4	3	2.8	
		Ten Laboratories With Best Results		
6	1.3	PH.D 10	B.A. (M.T.)[2] 4	Biochemist B.S. PH.D.
6	2.0	4	4	Technician
6	2.6	B.S. (M.T.)[2] 6	B.S. (M.T.)[2] 6	Technician B.S.
6	2.8	B.S. 6	B.S 6	Technician B.S.
6	3.6	B.S. (M.T.)[2] 5	B.S. (M.T.)[2] 5	Pathologist B.S. M.D.
6	3.9	B.S. M.A. 4	B.S. (M.T.)[2] less than 1	Biochemist B.S. M.A.
5	4.0	5	5	Pathologist B.S. M.D.
6	4.2	B.S. (M.T.)[2] 8	B.S. (M.T.)[2] 8	Pathologist B.S. M.D.
5	4.6	B.A. 10	4	Director B.A. M.D.
5	5.1	PH.D. 10	B.S. 3	Biochemsit B.S. M.A. PH.D.
Average	3.4	6.8	4.6	

[1]Experience defined as limited to chemistry.
[2]M.T. (A.S.C.P.).
[3]Part-time pathologist.

of the upper 10 group show an average experience record of 4.6 years while the lower 10 group shows an average of 2.8 years. (The average figures for the lower 10 group are somewhat misleading since they are heavily weighted by two people claiming 10 years experience). The lower 10 group could be characterized by a consistent lack of experience or special training of both "calibrator" or analyst.

Examination of educational attainments of both groups shows a much greater trend to graduate degrees in the upper 10 group.

No striking differences can be seen in the educational attainments of the directors of the laboratories in the two groups.

Five laboratories appearing in the lower 10 group are listed as being directed by pathologists. In four of these five instances, the pathologists were part-time and it is not certain whether the pathologist intended to imply nominal responsibility or actual active direction of the clinical laboratory.

The upper 10 laboratories reported at least five out of six unknowns correctly and had a composite average error (expressed as per cent of total) of 3.4 per cent. The lower 10 laboratories reported no more than two out of six unknowns correctly and had a composite average error of 16.4 per cent. The association of greater experience and superior training with the more accurate results is too large to be accidental.

The impact of experience and training in chemistry on survey results is clearly shown, and this applies to both the person setting up the method as well as the analyst.

One laboratory agreed to perform the determinations using analysts of widely varying experience. These people all used the same methods, same instruments and same standardizations. These methods were chosen and standardizations were prepared by a graduate chemist. Nine people analyzed the survey specimens. The group included four student

technicians with experience of 13 weeks in duration, one pathologist and four graduate technicians with experience ranging from one to five years in clinical chemistry. None of the determinations were reported in error.

From this additional information we conclude that the person responsible for choice of method, the preparation of reagents and the standardization and calibration of methods is of prime importance.

A separate analysis of the group of 18 hospital laboratories which participated in the original survey (survey I) showed that 85 per cent of the determinations of this group were reported correctly. This is significantly better than the whole group in this survey and is a definite improvement over the percentage of correct results reported by this same group in surveys I and II, which were 69 and 62 per cent, respectively.

DISCUSSION

Relation of survey results to every day accuracy

It is evident that under conditions of any such study as this, it is impossible to prevent the determinations being handled with special care. Even if the unknowns are submitted with routine samples the analyst can not help but be aware of conditions of testing. It is therefore reasonable to assume that in most cases the results reported are the best efforts of the personnel involved. It appears likely that the daily routine performance is measurably less accurate than the results given here. Even if the daily performance were as good as the survey results, this general level of accuracy is unsatisfactory and there is definite need for improvement.

The effect of methods and training of personnel

Since special training in chemistry would imply a better basis for choice of methods as well as more skilled technique, it is impossible in this sort of survey to separate methods per se from the people who use them. Therefore we emphasize the comparative data on methods must be interpreted with this important reservation.

The results show a measurable superiority of certain methods in routine use. Sound methods are basic to accurate results but even the best methods cannot assure accuracy when applied by an unskilled analyst. The magnitude of errors shown in Tables V and VI are larger than the inherent error of any of these methods in the hands of a trained chemist or properly supervised technician. The results roughly indicate the order of accuracy of these methods in the hands of variously trained people under practical working conditions. For example, the modified Sendroy method[3] is one of the best current methods for determining serum chloride. It does not appear accidental that the results with this method were demonstrably superior. It is also of considerable interest that the most accurately determined unknowns were those of serum protein and that this is the only determination which improved in accuracy over the period of time of the three Connecticut surveys. This improvement appears to be related in time, at least, to the widespread adoption of a biuret colorimetric procedure.

Comparison with other surveys

In the Pennsylvania survey of Belk and Sunderman,[4] 95 pathologists were asked to give opinions as to factors contributing to "inaccuracies and other unsatisfactory conditions in clinical laboratories." Factors of importance were given according to frequency of listing as:

1. Poorly trained technicians (82).
2. Inadequate number of technicians (80).
3. Lack of understanding between pathologist and staff (64).
4. Poor equipment (63).
5. Insufficient floor space (57).
6. Miscellaneous factors (39).

It was our plan originally to study the effects of economic factors and laboratory administration as suggested by the report of Belk and Sunderman. When it became evident from the original data that the professional qualifications of laboratory workers exerted a decisive influence on the accuracy of results, the further inquiry was not done.

We therefore do not have any data which directly bears on the opinions reported by Belk and Sunderman. We have demonstrated that the quality of personnel, particularly the person selecting, setting up and supervising the performance of tests is decisive in obtaining accurate results in clinical chemistry. We feel this demonstrated relationship between supervisory personnel and accurate work is probably of first order of importance.

SUMMARY

1. A third survey of common chemical determinations is reported.

2. The results show definite improvement in gen-

eral performances, with the most striking improvement in the hospital laboratories comprising the original group surveyed in 1948.[1]

3. The importance of special training of the person responsible for the standardization and supervision of performance of chemical tests has been demonstrated.

4. Poor results are associated with inexperience and inadequate training or both.

5. Certain methods are demonstrated to show significantly better results than others under the conditions of this study.

6. The survey shows a need for continued effort to improve laboratory standards in clinical chemistry, since the general level of accuracy is still unsatisfactory.

ACKNOWLEDGMENT

The expenses of this survey were defrayed by a grant from the Connecticut State Medical Society through its Committee on Public Health.

The survey was authorized by the Connecticut Society of Pathologists as a part of its program to improve laboratory standards. The opinions expressed by the authors are their own and do not necessarily represent the official views of the Society of Pathologists.

BIBLIOGRAPHY

1. Snavely, J. G., and Golden, W. R. C.: A survey of the accuracy of certain chemical determinations. Conn. State Med. J., 13:190-193, March 1949.

2. Snavely, J. G., and Golden, W. R. C.: The accuracy of certain common chemical determinations. Second survey. Conn. State Med. J., 15:667-8, August 1951.

3. VanSlyke, D. D., and Hiller, A.: Application of Sendroy's iodometric chloride titration to protein-containing fluids. J. Biol. Chem. 167:107-24 (1947).

4. Belk, W. P., and Sunderman, F. S.: A survey of the accuracy of chemical analyses in clinical laboratories. Amer. J. Clin. Path. 17:853-61, (1947).

PROPHYLAXIS OF RHEUMATIC FEVER

DANIEL F. LEVY, M.D., *New Haven*

The Author. *Attending physician, Grace-New Haven Community Hospital*

IT WILL be recalled that John Bunyan referred to tuberculosis as "The Captain of the Men of Death." As late as 1917 Sir William Osler mentioned the fact that pneumonia had become "The Captain of the Men of Death" rather than tuberculosis. At the present time heart disease has outstripped all other pathologies in causing death. For example, in 1947 diseases of the heart caused 35.4 per cent of the total deaths, cancer 17 per cent, intracranial lesions of vascular origin 11.3 per cent and accidents 5.4 per cent. Pneumonia, on the other hand, dropped down to 2.8 per cent and all forms of tuberculosis 2.7 per cent. This is quite a contrast from the year 1900 when heart disease caused 6.2 per cent, cancer 3.7 per cent. Tuberculosis led them all with 10.4 per cent and pneumonia was next with 9.2 per cent of the total deaths in this State. In 1951 heart disease reached the all record high of 42 per cent of all deaths. These figures are quoted from the Connecticut Health Bulletin.[1] Of course, there are many reasons that accompany these changes. There has been a tremendous decline in infant mortality and in infectious diseases. There has been a considerable alteration in the per cent distribution of population by age. Let me quote but one example. In the year 1900 the Connecticut population from age 45 upward was 21.8 per cent, whereas in 1940 it was 29.6 per cent.

It is difficult to determine the exact percentage of heart death which is due to rheumatic heart disease as compared, for example, with deaths due to diseases of the coronary arteries involving myocardial infarction. This has markedly altered. In a recent conversation with Dr. Paul D. White of Boston, he told me that it was apparently true that whereas death from rheumatic heart disease was the leader of the cardiac group in the early part of this century, it had now become only a small fraction of that figure. In place of this, coronary disease and degenerative cardiac diseases in general were very

Read at the Eighteenth New England Health Institute (University of Connecticut) June 20, 1952

strongly in the ascendency. This, of course, is but one index of the results of the great improvement in the control of infectious diseases. Nevertheless, it still must be remembered that as a cause of death among children, rheumatic heart disease is still a "Captain of the Men of Death."

It is now universally conceded that rheumatic fever is a sequel to an infection brought about by hemolytic streptococci (Lancefield's Group A). It should be clearly understood that it is not a disease caused directly by the streptococcus itself. It is, however, a later, deferred, response on the part of the patient to streptococcal infection of this type. It is definitely characterized by the development of antibodies to some of the antigenic components of the Group A streptococci. Such products as antistreptolysin O, antifibrinolysin and other substances may be mentioned in this connection. It has been observed that these antibodies occur in higher concentrations and earlier after streptococcal infections where rheumatic fever follows than in those who escape rheumatic fever. There is, however, no known serologic test which is definitely and positively indicative of rheumatic fever. It might be pointed out that the formation of gamma globulins is more marked in those individuals who have rheumatic fever than in other streptococcal infections which do not have the rheumatic sequel. It is probable that this increased activity or hypersensitivity is produced by a succession of Group A streptococcal infections. Animal experimentation and clinical observation is still being conducted in this field. It should be pointed out that insofar as we know, the only organisms that are capable of producing the sequel of rheumatic fever are those belonging to the Group A streptococci. It is for this reason that one of the chief prophylactic measures in connection with rheumatic fever is directed toward the avoidance of streptococcal infection.

Of course, it should be noted in passing that there are certain other valuable adjuncts in the prevention of rheumatic fever, for example, the avoidance of contact with streptococcal infection by various means. It is not my purpose here to discuss the question of familial tendency, familial exposure nor the variation of rheumatic state in different portions of the country or several other related problems. However, one example might be mentioned. We in New Haven for the past two years have been making an investigation as to whether or not dental caries plays any part in the recurrence of rheumatic heart attacks. This project, initiated under the auspices of the New Haven Heart Association, will in the future be continued by them. It is hoped that it will show whether or not the care of dental caries has any significant relationship to rheumatic recurrences when all of the other factors in the controls are the same.

It is really the object of this paper to discuss the control of streptococcal infection, thereby avoiding its frequent sequel, the rheumatic process. In previous years many groups interested in the question of rheumatic fever prophylaxis have confined their efforts to treating those who have already had attacks of rheumatic heart disease. It seems to me, however, that the recent turn of events has fully justified a matter that a number of us have been urging for a considerable period: the avoidance of the first attack. It is far better to lock the stable before the horse is stolen.

Insofar as streptococcal infections are concerned, it was fortunate indeed that sulfanilamide, which Gerhard Domagk discovered in 1932, was effective against hemolytic streptococcal infections. After sulfanilamide came sulfapyridine, sulfathiazole, sulfadiazine and a number of other sulfonamides. To a considerable extent sulfonamides were used in cardiac clinics in order to prevent recurrences of rheumatic fever or further damage to hearts already afflicted with rheumatic heart disease.

With the advent of penicillin a new and powerful weapon was placed in the hands of workers in this field. Of course it must be stated that other antibiotics such as aureomycin, terramycin and chloromycetin are also effective against streptococcal infections.

A most convincing chapter in the prophylaxis of acute rheumatic fever was written by Wannamaker, Rammelkamp, Denny, Brink, Houser, Hahn and Dingle.[2] These men did their work among soldiers. "The soldiers reporting to sick call with respiratory symptoms who showed either exudative tonsillitis or pharyngitis or an oral temperature of 100° F or greater were admitted to the hospital." Shortly thereafter each patient was examined by a member of the professional staff. Blood counts, cultures of the tonsils and pharynx as well as specimens of serum were obtained in each case. The patients whose serial numbers ended with an odd digit received no specific treatment and served as controls. About 1,178 cases were treated with depot penicillin and about 1,162 cases were not so treated. The

treated cases were divided into three groups. One group was given 300,000 units of procaine penicillin G in peanut or sesame oil, followed by 300,000 units in 48 hours and 600,000 units in 96 hours. In the second group 300,000 units were given immediately followed by 300,000 units in 72 hours. In the third group 600,000 units were given immediately. The whole study is a very remarkable one. The authors note that data collected on rheumatic subjects show that reinfection with a new type of streptococcus frequently occurred when the interval between the onset of the observed attack of exudative tonsillitis or pharyngitis and the onset of rheumatic fever was prolonged. Excluding those cases of rheumatic fever developed after a 45 day interval between the two diseases, the results were 2 cases of rheumatic fever in the treated group and 28 in the control patients. The authors stated that these data indicate that penicillin therapy in acute streptococcal infections almost completely prevents the subsequent occurrence of acute rheumatic fever. In addition to this, "the most marked inhibition of antibody was that obtained by three injections of penicillin over a 96 hour period totalling 1,200,000 units in comparison to the suppression of antistreptolysin by either a single injection of 600,000 units or two injections of 300,000 units each given 72 hours apart."[2]

Of course, the authors of the above paper did not give penicillin over a long period of time. Nevertheless, their results are exceedingly striking.

There are those today who advocate the method of continuous daily oral penicillin. By this method, even those who are carriers of hemolytic streptococci not only have their infections completely held in check, but in the overwhelming majority of cases the carriers have the organisms cleared from the pharynx.[3] The dosage of penicillin when given orally is usually 100,000 to 200,000 units three times a day. In many clinics a total amount of 300,000 units a day is deemed sufficient. It should be emphasized that the drug be given some time before meals, preferably a half hour or an hour before the ingestion of food, and certainly if given after meals an adequate time ought to elapse for the emptying of the stomach: three hours or more.

There are others who believe that prompt treatment of hemolytic streptococcal respiratory infections is very effective. For those who desire to use this method the treatment should be carried on for at least ten days and with adequate dosage.[3]

Of course, when one considers those children who already have rheumatic heart damage, the problem is somewhat simplified. One realizes that any new increment of rheumatic fever may produce very serious additional cardiac damage and, therefore, in these cases most of the clinics are giving continuous daily oral penicillin. There are very definite advantages in giving penicillin orally. In the first place it does away with an intramuscular injection. This, especially in the case of children, is often distressing. Secondly, oral penicillin gives rise to fewer side reactions than when penicillin is given intramuscularly. Unless it is necessary to attain a very high blood level of penicillin, and that over a prolonged period of time, oral penicillin is adequate. There are, of course, a few cases such as bacterial endocarditis where penicillin must be given parenterally and in high dosage.

We now come to a matter which, to me, is one of the most important in connection with this whole topic. Not infrequently do we hear doctors state: "I don't think I'll give penicillin." And they ask: "What shall I do when the patient really needs penicillin?" Of course, the implication is the development of penicillin resistance. In answer to this it must be stated that, insofar as the hemolytic streptococci are concerned, with adequate dosage there is no evidence that penicillin resistance develops. It may be true that some of the throat flora have an apparent elevation in penicillin resistance following the continued use of small doses of penicillin. However, if one wishes to overcome this resistance, a large dose of penicillin will practically always be effective.[4]

It should be emphasized that in the younger age groups, when an individual has an illness accompanied by a fever and signs of respiratory infection, hemolytic streptococci are very frequently present. Under these circumstances it is well to give the patient penicillin in adequate dosage. The therapy should be quickly started and continued for an adequate length of time in order to prevent recurrence. If the illness is due to a hemolytic streptococcus the response is prompt. If fever continues for more than two days under penicillin therapy, then a change in antibiotics is indicated. In those children where rheumatic fever is present in the family, it is perhaps best to give daily oral penicillin for considerable periods, especially when the patient has been in contact with those suffering from hemolytic streptococcal illness.

It is difficult to understand the thought of those men who, while being perfectly willing to give a child who has already had an attack of rheumatic fever usually accompanied by rheumatic heart disease, continuous daily doses of oral penicillin, nevertheless object to penicillin prophylaxis when a child without rheumatic fever presents itself with a sore throat accompanied by fever. The arguments set forth are usually that we have no definite proof that hemolytic streptococci are present. In answer to this it should be pointed out that Wannamaker et al[2] found 85.6 per cent of Group A streptococci on throat culture in the first of their control groups, whereas Massell[3] found that 80 per cent of the cases were positive for hemolytic streptococci prior to therapy. Furthermore, Massell states:[3] "Prompt penicillin treatment of all hemolytic streptococcal respiratory infections, as a prophylactic measure, is especially applicable to the problem of preventing initial attacks of rheumatic fever. Since about 50 per cent of hemolytic streptococcal infections are either subclinical or so mild that they are not readily recognizable, this method of prophylaxis should not be substituted for the more reliable method of continuous daily oral penicillin in individuals who have had a previous attack of definite rheumatic fever." The emphasis should be placed upon the fact that since so high a percentage of hemolytic streptococcal infections are not recognizable or are mild, there can certainly be no objection to a ten day regimen of penicillin when a child or young person presents himself with a sore throat and a fever.

In closing, I should like to state that at the New Haven Rheumatic Fever and Cardiac Clinic, which is headed by Dr. Ruth Whittemore, between 120 and 130 children are being given continuous daily doses of oral penicillin in the amount of 300,000 units. These children are already afflicted with rheumaitc heart disease. Of course the clinic works in cooperation with the attending physician. It is my understanding from Dr. Whittemore that there have been practically no cases of allergic manifestations. In the entire group there was possibly one and that was questionable. Dr. Whittemore, of course, was referring to oral penicillin and not injections of procaine penicillin.

It is my hope that information of the character contained in this paper be widely disseminated among physicians and especially those physicians who have charge of young people, so that the first attack of rheumatic fever may be prevented by the use of antibiotics. This matter calls for education all along the line, of parents, of teachers and nurses, and of physicians themselves. We are fortunate indeed in having a nontoxic substance which is a powerful weapon against one of the great destroyers of our youth.

REFERENCES

1. Haenszel, W. M.: Conn. State Department Health Bulletins, September 1948, May 1949; June and August 1950; also Conn. Health Bulletin April 1952.

2. Wannamaker, L. W., Rammelkamp Jr., C. H., Denny, F. W., Brink, W. R., Houser, H. B., Hahn, E. O., and Dingle, J. H.: Prophylaxis of Acute Rheumatic Fever. Amer. Jour. Medicine, Vol. X, No. 6, June 1951.

3. Massell, B. F.: Present Status of Penicillin Prophylaxis of Rheumatic Fever, Modern Concepts Cardiovascular Disease, Vol. XX, No. 9, September 1951.

4. Kohn, K. H., Milzer, A., and MacLean, H.: Oral Penicillin Prophylaxis of Recurrences of Rheumatic Fever, J. A. M. A., 142-20, January 1950.

INTERNAL DRAINAGE IN THE TREATMENT OF PSEUDOCYSTS OF THE PANCREAS

Said H. Tarabishy, M.D., *Waterbury*

The surgical treatment of pancreatic pseudocysts has undergone a considerable change in the last two decades. A series of new operations has been developed. The main issue at the present time is the evaluation of the new approach in management, namely, internal drainage.

Within a year period three cases of pancreatic pseudocysts were treated at the Waterbury Hospital by pancreato-cysto-gastrostomy with gratifying results. This report is made mainly because of the revealing postoperative roentgenographic studies carried out in one of these cases. For the first time evidence is presented to show that gastric contents entered freely into the cystic cavity without interfering with the obliteration of the pseudocyst nor causing any exacerbation of the chronic pancreatitis.

SURGICAL PATHOLOGY

The understanding of the pathogenesis of the pancreatic pseudocysts is all important in determining the mode of their treatment. Pinkham[18] and Meyer et al[14] recently covered their pathological features. Pseudocysts of the pancreas are sequelae of trauma[7] or pancreatitis. The percentage of either as etiological factor differs in different series depending on the type of population served by the hospital reporting. This explains why in the series reported from the Cook County Hospital, 51 per cent were of traumatic origin.[14]

These pseudocysts are encountered in intrapancreatic or extrapancreatic positions. The greater proportion is found lying in the lesser peritoneal cavity presenting in one of three sites: Under the gastrocolic ligament; under the gastrohepatic ligament; or between the leaves of the mesocolon. Although these are the usual sites, pancreatic pseudocysts may dissect retroperitoneally where they may compress the kidneys or extend into the pelvis where they may be mistaken for an ovarian cyst as in the case reported by Boseman.[6]

The wall of the pseudocyst is formed by dense connective tissue varying up to 3 cm. in thickness. Numerous strands and dense adhesions extend to the parent surfaces, namely the structures which delimit the lesser omental sac.

These pseudocysts may complicate in two ways: they may compress the adjoining organs often causing jaundice as a result of pressure on the biliary ducts or nausea and vomiting as a result of interference with peristalsis or compression of the duodenum or the stomach; they may rupture through rents in the gastrohepatic or the gastrocolic omentum. The cystic contents then leak into the general peritoneal cavity initiating a diffuse peritonitis.[11] There is only one report of spontaneous rupture of a pseudocyst into the bowel.[1]

TREATMENT

Obviously the pathological changes in the biliary tract, the severity and extent of the pancreatitis, the presence of external or internal pancreatic deficiency, together with the associated gastric or hepatic lesions affect the ultimate result of the surgical treatment. In a case reported by Griessmann[8] diabetes disappeared after pancreato-cysto-jejunostomy. One could not be sure if this was the result of decompression or the clearing up of pancreatitis. On the other hand, a good number of these patients will continue to complain of symptoms after ablation or obliteration of the pancreatic pseudocysts inasmuch as these are sequelae and not primary pathological processes.

Ideally, total extirpation of the pseudocyst is the procedure of choice. This may be feasible in the smaller cysts, particularly those located in the tail of the pancreas. It is, however, a procedure not without great hazards in the hands of its advocates and often it is technically impossible because of the major adhesions enveloping the cyst. Trauma to the pancreas during the process of excision may result in a pancreatic fistula. The dissection may become complicated by the proximity of the bile ducts,[4] portal vein or superior mesenteric vessels, or by the occurrence of adventitious vessels in the cystic wall.

From the Surgical Department, Waterbury Hospital

In case of portal vein obstruction as a result of cysts in the neck and head of the pancreas, chronic obstruction results in extensive collateral circulation with the posterior abdominal veins producing distorted tortuous friable veins over the posterior abdominal parietes. Such collateral vessels will render the excision of these cysts extremely hazardous. Maingot[11] states the mortality rate of excision of these pseudocysts ranges between 10-25 per cent if the cysts are successfully removed and a mortality of 55 per cent is given when unsuccessful attempt at excision was made.

It is these considerations that made the easily performed external drainage introduced by Jordon Hoyd and the marsupialization and external drainage technic introduced by Gussenbauer in 1882 become popular for many years. Different authors still consider it the method of choice.[13,20] Although a low mortality rate for this procedure is given by Rossing, 4 to 5 per cent,[12] the morbidity is unusually high. Brilhart and Priestly[3] who are advocates of marsupialization and external drainage gave the average duration of the draining sinus as 3.3 months in a series of eleven cases. In Pinkham's review of ten cases, drainage persisted for an average of six to ten weeks and in one case for six months, with some of the cases developing marked skin irritation and painful excoriations.[18] Postoperatively, the externally drained cases require special attention to fluid, electrolyte and nitrogen balance because of the metabolic disturbances resulting from the continuous and frequently excessive drainage of secretions.[14] Postoperative bleeding has been reported.[19] Warren[21] states, "Cumulative experience has shown marsupialization is followed by recurrence or by persistent external fistulae. Drainage from these fistulous openings may persist for many years and escaping ferments can cause painful erosions about the stoma. Secondary infection of the sinus and recurrent cyst may contribute to intractability of drainage."

The treatment of persistent fistulae resulting from externally drained cysts varied from irradiation to cauterization and finally to implantation of the fistulous tract to a hollow organ by Kehr. From this last procedure developed the concept of primary internal drainage of Jedlika which culminated in the procedure of Juraz.

Primary internal drainage by anastomosing pancreatic pseudocysts to the jejunum (Hahn 1923), to the gallbladder (Walzel 1925), or to the stomach (Juraz 1929), has become increasingly more popular as evidenced by the number of case reports and discussions published in the last few years.[2,5,8,9,12-17,21,22]

Follow up studies from reoperations or autopsy showed rapid obliteration of these pseudocysts.[16] In the case reported by Muller in which a pancreatic pseudocyst of 1100 cc. capacity was anastomosed to the duodenum, there was no evidence of the cyst or of its connection to the duodenum at the postmortem examination six years and nine months later when the patient died of carcinoma of the rectum.

Internal drainage reduced the postoperative morbidity to a minimum. Patients left the hospital within ten to fifteen days postoperatively free of the offensive sequelae of external drainage, the painful irritation and maceration of the skin resulting from the prolonged drainage which may last months, years and perhaps end in fistula formation.

The main objections to internal drainage are theoretical. They are based on the possibility of infection from the gastrointestinal tract and activation of the pancreatic enzymes which could endanger the suture line tissues. Because of such reasoning Walzel anastomosed the pseudocyst to the gallbladder and to avoid any possible communication with the intestine he ligated the cystic duct. The shortcomings of such a procedure are readily apparent: the technical impossibility of anastomosing the gallbladder with cysts of the tail of the pancreas; the necessity of a well functioning gallbladder whereas gallbladder disease is quite frequently associated with pancreatic pseudocysts; it entails the loss of the gallbladder function; inflammation of the gallbladder results in cessation of absorption with resulting retention and rupture of the cyst.[22]

There are some successful results on record but on the whole this technique is not satisfactory.[14]

The choice of the anastomotic site remains therefor among the stomach, duodenum and jejunum. In all probability the location of the cysts was why one or the other hollow organ was selected for anastomosis by different operators. Kunc,[12] confronted with two pancreatic pseudocysts in a case, did a pancreato-cysto-duodenostomy for the cyst in the head of the pancreas and a pancreato-cysto-gastrostomy for the one lying behind the stomach. On theoretical considerations alone, the duodenum or upper jejunum may be the best choice for anastomosis. It is there the pancreatic duct empties nor-

mally. Ombredanne in 1911 did the first pancreato-cysto-duodenostomy, the first successful case was done by Kirschner in 1929.

Anastomosis of the pancreatic cyst to the jejunum in a side to side anastomosis[8] or by Roux Y procedure[9,15] has been used with gratifying results. Griessmann advised closure of the end of the distal loop of the Y performing a side to side anastomosis to the cyst to ensure a wider stoma. Kafka[8] reported his collected cases of eight pancreato-cysto-jejunostomies without any deaths. The two cases in the Cook County Hospital series[14] ended fatally with suppurative peritonitis.

The main objection to pancreato-cysto-jejunostomy is its being a prolonged technical operation in a patient who is quite ill. On the other hand it might be the preferable procedure or the only choice in cases with a cyst presenting through the mesocolon.

The fact that most pancreatic cysts are located in the lesser sac and closely related to the posterior aspect of the stomach, the anastomosis to this organ seems to be the most logical on topographical grounds. Furthermore, the wall of the cyst is firmly attached to the stomach making posterior pancreato-cysto-gastrostomy a very safe procedure as far as possibility of digestion of suture line and leakage.

This technique has been criticized because of the possibilities of hemorrhage from the cyst, infection, reactivation of pancreatic ferments resulting in pancreatic necrosis and entrance of gastric contents into the cyst.

Kafka reported one postoperative death as a result of hemorrhage from an eroded vein in the cyst wall. However, this complication was also encountered in externally drained cysts. Maximer and Maximer[13] warned of the dangers of pancreato-cysto-gastrostomy. They reported a case where repeated massive gastric hemorrhages occurred postoperatively necessitating gastric resection. They stated, however, they had "no positive evidence the pancreato-cysto-gastrostomy was the cause of ulceration. The cyst had completely disappeared when the gastric ulcer was bleeding actively. Therefore, it could be considered as a concomitant condition rather than a sequel." This concomittant ulceration was also observed in one of the cases of Kunc.[12]

The possibility of pancreatic necrosis as a result of reactivation of pancreatic enzymes has not been noted in any of the reported cases, all of which had a smooth uneventful postoperative course with no remarkable temperature elevation, vomiting or epigastric distress to suggest an acute exacerbation of pancreatitis.

The possibility of entrance of the gastric contents into the cystic cavity after pancreato-cysto-gastrostomy was always debated on the basis of postoperative roentgenographic examinations and hypothetical reasoning. Barium studies were usually performed not earlier than on the 10th to 12th postoperative day except in the case of Brandenburg et al[2] when barium meal studies were done on the 6th postoperative day. In all successful cases there was no evidence of entrance of barium into the cyst. In some there was tenting of the stomach at a point corresponding to the site of anastomosis. On the basis of such studies Kunc doubted if any reflux really took place as "none was ever proved radiologically."[12] On these grounds he built a hypothesis on the mechanism of emptying. He maintained: "The spasm at the operative site with increased peristaltic activity could prevent the penetration of gastric contents into the cyst." On the other hand, he believed: "After a peristaltic wave has passed, a fall of pressure ensues at the site of anastomosis to a lower level than that within the cyst, with a subsequent sucking effect on the cystic contents."

Considering the fact that these pseudocysts may be obliterated in as short a time as 24 hours as in the case reported by Berkay,[1] it seems that these x-ray studies could not justify the conclusions reached until more roentgenographic studies are done very early in the postoperative course. In the case reported here, barium studies were done on the 6th postoperative day, repeated on the 17th day and three months later.

CASE REPORT

A sixty-two year old farmer was admitted to the Waterbury Hospital on May 5, 1950, with a chief complaint of persistent epigastric pain and vomiting of one week's duration. This man always worked regularly, never losing a day of work because of illness. About eighteen months before this admission he started to imbibe heavily of beer. The average amount consumed was four to five quarts each night until during the last six months when he developed an intolerance to alcoholic beverages and his intake was tremendously reduced.

Physical examination on admission showed: T. 100.8 degrees F., P. R. 88, R. R. 20 and B. P. 134/70. Patient was nauseated and vomiting bilious fluid. He presented moderate symptoms of paralysis agitans which had been present for many years. There was no evidence of jaundice of the skin or sclerae. The main findings were in the abdomen. This was enlarged with moderately hard, finely nodular mass palpable from the left subcostal margin to the crest of the left ileum and to the right of the umbilicus.

Routine laboratory studies including complete blood count, blood sugar, Mazzini and urinalysis were not remarkable. Blood nonprotein nitrogen was 58 mgm. per cent, evidently the result of vomiting and loss of fluids and electrolytes.

HOSPITAL COURSE

In the first twenty-four hours, the patient felt constantly nauseated, complained of pain in the abdomen and vomited repeatedly. Then came a sudden exacerbation of pain



FIGURE 1

accompanied by profuse perspiration and a rapid pulse. The abdomen was rigid and tender. Blood pressure was 160/70. A diagnosis of ruptured pancreatic cyst was made and confirmed at operation four hours after the onset of the acute episode. Free, dark, sanguinous fluid was in the peritoneal cavity. It was pouring through a rent about 1 cm. in the thickened gastrohepatic omentum. The total amount of fluid removed from the abdomen and the cyst measured 2500 cc. The cyst involved the lesser sac, protruded at the gastrocolic ligament and displaced the transverse colon to the right side of the abdomen. The wall of the cyst varied from four to six mm. in thickness.

The rent in the gastrohepatic ligament was closed with interrupted chromic sutures. A transgastric pancreato-cystogastrostomy was then done in the prepyloric region and the abdominal cavity drained for twenty-four hours. The sanguinous fluid removed at operation did not contain trypsin.

Microscopic examination of the piece removed from the posterior gastric wall showed: "Gastric serosa presenting pronounced fibroblastic and mesothelial proliferation with the surface covered with necrotic material and clotted blood. There was much infiltration by round cells and few polymorphonuclears."



FIGURE 2

POSTOPERATIVE COURSE

The highest temperature was 101 degrees F. which gradually returned to normal. The patient was ambulatory on the second postoperative day. He appeared slightly jaundiced with an icterus index of 15.6 U. The serum amylase was 88 U. (Symogii). Jaundice was apparently the result of absorption of decomposed blood from the abdominal cavity. It cleared spontaneously in four days. On the third postoperative day the patient was started on fluids by mouth and on the fourth day he was given jello, junket and custard in addition to amigen in quantities of 200 cc. every two hours.

Fluoroscopic examination was undertaken on 5-13-50. It showed the stomach communicating to a cyst cavity measuring 10 × 12 cm. (Figure 1). Twenty-four hours later a survey film of the abdomen showed some barium retained in the cyst area but after forty-eight hours barium was almost completely absent. A barium examination was repeated eleven days later, just before the patient was discharged to his home. On this occasion there was only a small outpocketing from the stomach at the site of anastomosis.

Early in the postoperative course the patient had an unusually rapid pulse of 160-170 per minute and associated with rapid breathing. This was observed mainly after drinking fluids. It could very well have been a reaction due to the entrance of gastric contents into the cyst cavity.

After his discharge from the hospital, the patient had some episodes of pain in the epigastrium but had no nausea, vomiting or indigestion. When he was seen on a follow-up visit on September 25, 1950, he had gained 6½ pounds in weight. Fluoroscopic examination at this time showed a completely normal stomach (Figure 2). In March 1951, the patient was reported to be doing well except for occasional episodes of epigastric pain, presumably the result of chronic relapsing pancreatitis.

The chain of events in this case corresponds to that described by Koucky et al[11] characterizing cases of perforated pseudocysts. In their series of six cases with perforated pancreatic pseudocysts treated by external drainage, four died. This would lead one to wonder if the pancreato-cysto-gastrostomy was a factor in the survival of the case presented here. At least, it may be said that it eliminated the electrolyte and fluid imbalance which occurs with external drainage.

CONCLUSION

In the treatment of pancreatic pseudocysts or true cysts of the pancreas there has been a rapidly increasing cumulative evidence that internal drainage, because of its simplicity and greater safety and minor morbidity, is gradually replacing the time honored procedure of marsupialization and external drainage. Considering the equally good results of all methods of internal drainage, the simplest and most sparing procedure should be the best for the patient. Only the topographical relation of the cyst to neighboring organs should determine the choice of the hollow organ for anastomosis. Because of the usually very close topographical relation between the stomach and the pancreatic cyst, pancreato-cysto-gastrostomy should be given preference. In the presence of sufficiently extensive and firm adhesions, the simple sutureless transgastric or transduodenal technics already prepared by nature is the safest method.

SUMMARY

1. The surgical pathology of pancreatic pseudocysts is reviewed.

2. Marsupialization and external drainage have a high morbidity. The draining sinus may persist for months, years and sometimes results in a fistula formation.

3. Methods of internal drainage indicate an advance in the treatment of pancreatic pseudocysts. Only the topographical relations of the cyst should determine the choice of hollow organ for anastomosis.

4. A case of perforated pseudocyst of the pancreas treated by pancreato-cysto-gastrostomy is reported. Roentgenographic evidence is presented to show for the first time that gastric contents entered into the cyst cavity after a transgastric pancreato-cysto-gastrostomy with subsequent complete obliteration of the pseudocyst.

BIBLIOGRAPHY

1. Berkay, F.: Pseudocysts of pancreas and external drainage; J. Internat. Coll. Surgeons, 11:403, 1948.

2. Brandenburg, F. H., Maddock, S., and Schweitzer, R. J.: Cystogastrostomy; Ann. Surg., 133:219, 1951.

3. Brilhart, K. B., and Priestly, J. T.: Pseudocysts of the pancreas; Am. J. Surg., 76:151, 1951.

4. Carter, R. F., and Slatterly, L. R.: Factors Influencing the management of pancreatic pseudocysts; S. Clin. North America 411, April 1947.

5. Chodoff, J. R.: Pancreas pseudocysts; Ann. Surg. 128:981, 1948.

6. Collins, D.: Pseudocysts of the pancreas; Arch. Surg. 61:524, 1950.

7. Connally, E. A., and Lempka, A.: Pseudocysts of pancreas; Am. J. Surg., 74:805, 1947.

8. Griessmann, H.: The management of pancreatic cysts; Chirurg. 19:302, 1948.

9. Gurwitz, J., and Hurwitz, A.: Treatment of pancreatic cysts; Ann. Surg., 128:976, 1948.

10. Judd, E. S., Mattson and Mahorner: Pancreatic cysts; Arch. Surg. 22:838, 1931.

11. Koucky, John, Beck and Todd: Perforation of pancreatic pseudocysts; Surg. Gynec. & Obst. 73:113, 1941.

12. Kunc, Z.: Direct anastomosis between pancreatic cysts and intestinal tract; J. Internat. Coll. Surgeons 10:529, 1947.

13. Maximer Jr., S. R., and Maximer, S. R.: Pancreato-cysto-gastrostomy; Surg. 27:919, 1950.

14. Meyer, K., Sheridan and Murphy: Pseudocysts of pancreas; Surg. Gynec. & Obst., 88:219, 1949.

15. Migliaccio, A., and Laurelli: Pancreatic cysts; Surg. 24:54, 1948.

16. Muller, P.: Autopsy findings 6¾ years after pancreato-cysto-gastrostomy; Chirurg., 19:309, 1948.

17. Paul, M.: Pancreatic cysts; Brit. J. Surg. 37:99, 1949.

18. Pinkham, R.: Pancreatic collections following pancreatitis and pancreatic necrosis; Surg. Gynec. & Obst. 80:225, 1945.

19. Poer, D., and Stephenson, R.: Late results in the treatment of pancreatic cysts by internal drainage; Surg. Gynec. & Obst. 89:257, 1949.

20. Priestly, J. T.: Pancreatic cysts; S. Clin. North America 30:971, 1950.

21. Warren, K.: Pancreatic cysts; S. Clin. North America, 28:753, June 1948.

22. Zehrer, G.: On the operative management of pancreatic cysts; Chirurg 19:306, 1948.

HARNESSING THE VANISHING DOLLAR

FRANCIS T. FENN, JR., C.L.U., *Hartford*

It is a great honor and privilege to meet with this distinguished group of professional men and women. For one hundred and sixty years you have faithfully rendered one of the greatest services to your fellow citizens. Not only do members of the medical profession perform an outstanding service to mankind, but also no group provides a stronger bulwark for the American way of life and the principles that made our country so great.

My experience serving more than thirty clients in the medical profession during the past fourteen years has given me an insight into your problems. Furthermore, it has created in me a desire to help you solve some of the financial problems that are peculiar to the members of your profession. In this talk tonight we will suggest some new avenues for you to explore in attempting to reach a solution to some of these problems.

In order to give you a complete picture, it is going to be necessary for me to trespass into the field of law and taxes. Although all my statements have been carefully checked by my attorney, I want to emphasize the fact that I am not a lawyer and am not licensed to give legal advice. You should carefully check anything I have to say regarding legal or tax matters with your own attorney.

WHAT DO WE MEAN BY "THE VANISHING DOLLAR"

Perhaps the first thing that comes to your mind when we speak of the vanishing dollar is the effect that inflation has had on your pocketbook. Of course, this has served to make the value of your dollars depreciate, but what we are concerned with tonight is what happens to your earnings as your income goes up. I think that you know now that what I am talking about is the effect of income taxes on your earnings.

Before income taxes came into being on March 1, 1913, a doctor was allowed to keep all of the income he earned. Since that year, income taxes have steadily increased until now a large part of what a doctor earns is paid over to Uncle Sam. The table set forth below will illustrate what I mean:

NET TAXABLE INCOME	AMOUNT OF NEXT $1,000 KEPT BY DOCTOR	AMOUNT OF NEXT $1,000 THAT VANISHES IN TAXES
$10,000	$580	$420
15,000	470	530
20,000	380	620
35,000	320	680
60,000	200	800
100,000	100	900

Note: Figures shown in the above table assume the individual is single, and relate to net taxable income after exemptions.

Thus it becomes quite clear that the harder a doctor works and the more he earns, the less he is allowed to keep.

WHY HARNESS THE VANISHING DOLLAR?

Perhaps the answer to this question is obvious because none of us like the idea of seeing an increasing portion of what we earn winding up in mink coats, freezers and other wastes of government and corruption. I am sure that you as doctors would rather direct some of these vanishing dollars into providing better medicine, medical clinics, scientific research, medical scholarships, etc., for society. I am sure, that if you could, you would like to divert some of these vanishing dollars into providing more adequate security for your families and your old age. You would like to put yourselves on an equal footing with the corporate executive who may have a pension program, the costs of which are not taxed to him currently as income. Furthermore, you would like to enjoy the Social Security benefits which this corporate executive has, which may be the equivalent of from $7,000 to $35,000 of insurance.

HOW CAN THE VANISHING DOLLAR BE HARNESSED?

There are several plans that have been devised for harnessing the vanishing dollar. Before getting into the new plan of corporate medical practice, which now seems to be possible in Connecticut, permit me to comment briefly on two of these plans.

The first plan, which I shall refer to as "the

Address delivered before the 160th Annual Meeting of the Hartford County Medical Association at the Hartford Club, April 1, 1952

Boston plan," is a cooperative plan for doctors and hospitals that was developed by Mr. Leonard Mordecai, a life insurance consultant in Boston. This plan has been adopted by several doctors and hospitals in Boston.

Briefly the plan works as follows:

1. All of the doctors' fees go to the hospital.

2. All the doctors' expenses are paid by the hospital.

3. All bills are collected by the hospital.

4. The doctor receives a salary from the hospital, subject to change from time to time by mutual agreement.

5. The doctor receives a guaranteed retirement income from an insured annuity on which premium payments are not taxable income to the doctor under current law.

6. In cases where it seems appropriate and where the doctor is insurable, an adequate life insurance estate is arranged for him under a unique plan that requires only a comparatively small premium payment on the doctor's part.

Under this plan, a doctor is given an opportunity to devote full time to his specialty and receive an adequate income and pension. Furthermore, the hospital receives dollars that would otherwise vanish in taxes, which they can devote to an improved hospital and medical service for the public.

However, there is one serious drawback which probably limits widespread adoption of this plan by doctors and hospitals at the present time. The so called Hess Report, which appeared in the *Journal of the American Medical Association*, states that it is unethical for lay institutions to make a profit from a doctor's services. Until this problem is resolved, it would not seem that much progress can be made by doctors and hospitals in this area in working out a cooperative plan.

Another plan which has been developed in some states is known as "the Massachusetts Trust Plan." Under this plan a group of doctors form a trust similar to a corporation. A board of trustees is appointed and all the fees earned by the doctors go to the trust. All expenses are paid by the trust and doctors receive salaries from the trust. A pension plan is set up for the doctors on which the premiums are not taxable to the doctors as income.

There are many technicalities connected with the Massachusetts Trust Plan which I shall not go into here, because doctors in Connecticut are now permitted to incorporate. This, it seems to me, makes further a consideration of the Massachusetts Trust Plan unnecessary.

CORPORATE MEDICAL PRACTICE IN CONNECTICUT

The 1951 General Assembly of the State of Connecticut enacted into law, Public Act No. 342, which was signed by the Governor on June 29, 1951, and which has become section 1062b of the 1951 Supplement to the General Statutes of Connecticut. This Act has raised many questions in the minds of lawyers, and I shall not try to interpret it but will simply quote from the law as follows:

"Any three or more persons, all of whom shall be duly licensed pursuant to section 442a of the 1949 supplement to the general statutes and who shall furnish to the secretary of the state a certificate issued by the Connecticut medical examining board that they are so licensed, may associate to form a corporation without capital stock to own, operate and maintain a clinic for the study, diagnosis and treatment of human ailments and injuries by persons duly licensed, and to promote medical, surgical and scientific research and learning, such corporation to be subject to the provisions of chapter 251 of the general statutes; provided such corporation may not itself give medical or surgical treatment, consultation or advice, and provided only persons licensed pursuant to said section 442a and no others may be members of such corporation."

Without attempting to interpret the legal meaning of the above section of the Act, I submit to you that its intent is to permit licensed physicians to incorporate. This has tremendous significance because it opens the door in Connecticut to a way of solving the problem of the vanishing dollar.

PROFIT VS. NONPROFIT CORPORATION

The statute does not seem to make it clear whether the corporation can operate for profit or whether it has to be a nonprofit corporation. However, it seems to me, that there are several good reasons why it should be a nonprofit corporation which will qualify for exemption from federal income tax, under subsection (6) of section 101 of the Internal Revenue Code. These reasons are as follows:

1. It will be exempt from the corporate income tax.

2. The corporation could create a pension trust, the income of which would be exempt from federal tax under Section 165 of the Internal Revenue Code.

3. More dollars will be harnessed for public good through scientific and educational purposes.

The cost of devoting the corporation's net income

to charitable purposes, as compared with the conduct of the operation on a strictly business basis, is very small. For example, suppose ten doctors have formed a corporation that has a profit of $50,000 after paying all expenses, salaries and pension contributions. The following is a picture of about what they would give up in usable income in order to give the $50,000 profit to charitable, scientific and educational purposes.

	"PROFIT" CORPORATION	"NONPROFIT" CORPORATION
Profit before taxes	$50,000	$50,000
Corporate income tax exclusive of possible excess profits taxes	—20,500	—None
Net profit after taxes	$29,500	$50,000
Additional income taxes if distributed to doctors in 60 per cent tax bracket	—17,700	—None
Net for doctors	$11,800	$ None
Net for charitable, scientific, and educational purposes		$50,000

Cost of making $50,000 gift—$5,000 per doctor, assuming that there are ten doctors—$1,180 for each doctor, and he controls the gift.

NONPROFIT MEDICAL CORPORATION WITH A PENSION PLAN

Let us assume that five doctors, who have been operating as individuals or who are already practicing medicine in a partnership, decide to form a corporation that will qualify as a nonprofit corporation which will qualify for exemption from federal income tax under sub-section (6) of Section 101 of the Internal Revenue Code. All the fees that these doctors earn will go to the corporation and all expenses will be paid by the corporation. A schedule of salaries, subject to change from time to time, will be set up for the individual doctors. In addition to this, each doctor, and all other employees of the corporation, will participate in a pension plan that provides 40 per cent of their salary as a retirement income at age 65. Besides this, certain death benefits will be provided for the participants in the pension trust.

Before getting into a comparison as to how this plan works out for the doctors in the corporation vs. the doctors as individuals or in the partnership, let us see how much additional income a doctor age 45 would have to earn as an individual in order to provide a thousand dollars per month pension for himself at age 65. The premium for this would be approximately $7,000 per year and if he is a member of our proposed corporation, he only has to earn $7,000 fees in order to provide this premium.

However, if he is an individual or a member of a partnership, and assuming that he is in the 60 to 70 per cent tax bracket, he will have to earn in the neighborhood of $21,000 in order to provide this $7,000 after taxes to pay the premium. Thus you can see how many vanishing dollars are harnessed in a situation of this kind.

Let us see how these five doctors will make out if they operate as a nonprofit corporation instead of as individuals or a partnership. Before getting into the illustration, I would like to point out that I have assumed that the doctors' expenses equal about 30 per cent of their aggregate fees. If they operate as a corporation instead of as individuals, they should obtain enough savings by pooling expenses and greater efficiency in order to provide the premium necessary to fund the 40 per cent pension for their employees.

I might also add that in the illustration set forth below, the term "total beneficial income to doctors" means the total income that goes to the doctors after taxes, either in the form of cash after taxes or net salary after taxes and contribution to the pension plan that will provide a benefit equal to 40 per cent of their salaries at age 65.

Now let us see how the comparison looks, realizing, of course, that marital status, number of dependents, outside income, charitable and other deductions would all cause variations in an actual case:

	FIVE DOCTORS AS INDIVIDUALS OR PARTNERSHIP WITH FEES OF $200,000	FIVE DOCTORS WITH $200,000 FEES IN NONPROFIT CORPORATION ON $100,000 SALARIES
Expenses without pension for employees	$60,000	——
Expenses with pension for employees	——	$60,000
Doctors' usable income after taxes on $140,000 Income after expenses	$100,000	——
Doctors' usable income after taxes on $100,000 Aggregate salaries	——	$80,000
Non-taxable contribution to pension	None	$25,000
Total beneficial income for doctors	$100,000	$105,000

Non-taxable profit for charitable, scientific, and educational purposes	None	$15,000	
Income taxes on doctors' $140,000 gross income subject to tax		$40,000	———
Income taxes on doctors' $100,000 aggregate salaries subject to tax	———	$20,000	———
Aggregate fees of five doctors		$200,000	$200,000

As can be seen from the above comparison, these doctors enjoy $5,000 more beneficial income in the nonprofit corporation than they do as individuals or in the partnership. In addition to this, they will receive substantial insurance benefits that would probably average $65,000 and they will be covered by Social Security, thereby receiving benefits of from $7,000 to $35,000 each. Also under the nonprofit corporation, $15,000 will be devoted to society in the form of charitable, scientific or educational benefits.

How many vanishing dollars have been harnessed? Twenty thousand dollars in all, or 50 per cent of the dollars that vanish in taxes if the doctors continue to operate as individuals or in a partnership.

HOW WOULD THE CORPORATE PLAN WORK OUT FOR AN INDIVIDUAL DOCTOR?

It would be impossible to work out an illustration that would fit every doctor. Each case would be different because the doctor's age, his income, the number of dependents he has in his family, the number in the medical corporation, etc., would all have a bearing on the results. I would be glad to work out a comparison for anyone who is interested and who will give me the facts.

However, to illustrate how the corporate plan might work out for the individual doctor, let us assume that one of the members of the group described before is a married man, 45 years of age, with three children. Last year his gross fees were $40,000. Let us compare his picture as an individual with that which he might have under the nonprofit corporate setup, assuming that his salary in the corporation is $20,000 per year.

As in the illustration with the five doctors, half of the dollars that vanish in taxes when this doctor operates as an individual are harnessed for society and the doctor's old age in the corporate plan. In addition to this, he has $1,000 more beneficial income when the nontaxable contribution to his pension is added to his net income after taxes. Pension and security is provided for his employees probably without any increase in the amount of his fees that have to be allocated to expenses.

	DOCTOR AS INDIVIDUAL WITH FEES AGGREGATING $40,000	DOCTOR WITH $40,000 IN NON PROFIT CORPORATION ON $20,000 SALARY
Expenses without pension for employees	$12,000	———
Expenses with pension for employees	———	$12,000
Doctor's usable income after taxes on $28,000 Income after expenses	$ 20,000	———
Doctor's usable income after taxes on $20,000 salary	———	$16,000
Non-taxable contribution to pension	None	$ 5,000
Total beneficial income for doctor	$20,000	$21,000
Non-taxable profit for charitable, scientific, and educational purposes	None	$ 3,000
Income taxes on doctor's $28,000 gross income subject to tax	$ 8,000	———
Income tax on doctor's $20,000 salary subject to tax	———	$ 4,000
Aggregate fees	$40,000	$40,000

Note: Naturally, outside income and charitable and other deductions would all cause variations in the above figures.

Because this doctor is married and has three children, he receives substantial Social Security benefits. In event of his death after he has been covered for a year and a half, his wife will receive an income of $150 per month as long as he has two children under 18 years of age. Then the income will drop to $120 per month until the last child reaches age 18. At that time her income ceases until she is 65 when she commences to receive a pension of $60 per month for life. If his children are young, these Social Security income benefits will be the equivalent to approximately $35,000 of life insurance.

Social Security will also provide him with an income of $80 per month when he retires at age 65. Assuming that his wife is alive at that time, this income will be increased to $120 per month when she becomes 65. The cost of these substantial Social Security benefits to the doctor is only $54 per year (plus a similar amount from the corporation).

In addition to the Social Security benefits outlined above, and assuming that the doctor is insurable, he will receive about $65,000 of life insurance. Thus his estate for his family will be increased by approximately $100,000 when insurance and Social Security benefits have been added, depending, of course, on his actual insurance benefit and the ages and number of his children.

At retirement age 65, assuming he continues to receive a $20,000 salary until that date, he will commence to receive his 40 per cent pension of $8,000 per year. In addition to the pension, he will have $1,440 from Social Security (assuming his wife is 65 or over) giving him a total retirement income of $9,440. After taxes are deducted from this, the net income that he has for retirement will be about half of his $16,000 net usable income after taxes that he will enjoy today.

The cost of providing $100,000 insurance and a pension of $9,440 would be approximately $6,000 after taxes, if this doctor were to provide these benefits an an individual. This would reduce his $20,000 net income as an individual to $14,000. Under the corporate plan he has all these benefits provided and $16,000 left over to live on. Thus he has $2,000 more usable income under the corporate plan than he would have as an individual, assuming he is going to provide the same protection for his family and the same retirement for himself.

In addition to the above financial gains, this doctor operating under the nonprofit corporation plan will be freed from all personnel, management and bill collecting problems. He will have more time to devote to his particular specialty and interest and will undoubtedly have more time for leisure. In addition to this, he will have the thrill that will come from knowing that a part of his earnings, which did vanish in taxes, are now going to society in the form of medical advancement, medical scholarships, etc.

SPECIAL BENEFITS FOR YOUNG DOCTORS

Although the nonprofit medical corporation offers benefits for all doctors, in my opinion, it offers unusual benefits to the younger doctor. These benefits can be listed as follows:

1. It gives him an opportunity for further education through medical scholarships and medical fellowships that will be established from the profit of the nonprofit corporation.

2. It offers him a better chance to specialize.

3. It gives him Social Security benefits equivalent to as much as $35,000 insurance when he has young children and needs these benefits most.

4. It gives him more insurance than he could possibly buy himself when his children are young and he has the greatest need for an estate.

5. It offers him a known liberal salary scale.

6. It gives him an opportuntiy to commence building a retirement income at an earlier date than he could otherwise do.

7. It provides all of his equipment and expenses without cost to him.

8. It gives him the prestige of being associated with an established group.

WHAT ABOUT THE DISADVANTAGES OF THE MEDICAL CORPORATION?

Some may feel that medical corporations present some difficult tax problem. This certainly could be true if the corporation is established to make profit. However, if the corporation is set up on a nonprofit basis and qualifies as a nonprofit corporation which will qualify for exemption from federal income tax under sub-section (6) of Section 101 of the Internal Revenue Code, then there should be no tax problem.

The expenses of incorporation may be thought to be high by some. However, these expenses are certainly minor when compared to the future benefits derived. We shall be glad to work out a comparison showing your financial picture under the corporation with a pension plan as compared to your financial picture today, without cost to you. Then you can decide whether or not you wish to proceed further with your attorney and other advisors.

Another objection that is brought up to the idea of medical corporations is the erroneous belief that salaries are fixed. This is, of course, no more the case than in an ordinary corporation and salaries can certainly be adjusted from time to time.

Perhaps the most serious disadvantage to the medical corporation that exists is the fact that some doctors feel that they would be losing their independence. It is undoubtedly true that the doctor who would not enter group practice and partnership because he feels he would not be happy should not enter into group practice in a medical corporation. There must be a team spirit in the medical corporate group just as there is in the medical partnership group.

However, for many men this feeling of a loss of

independence will be more than offset by the ability to specialize and freedom from all management cares. For these doctors the medical corporation offers greater independence, satisfaction, income and financial security.

CONCLUSION

Permit me to close by pointing out again that Connecticut doctors now have the door open to a new way to practice better medicine through corporate medical practice. As we have shown, it is quite possible that half the dollars that now vanish in taxes can be harnessed for the doctor's family, his old age security and society.

Corporate medical practice offers great opportunities for younger doctors and at the same time gives the older established physician a chance to let up a bit by using dollars that would otherwise vanish in taxes to help younger physicians to establish themselves as a part of his corporation.

One of our oldest and noblest professions can now use one of the tools of the American free-enterprise system—the corporation—in its fight against socialism and state medicine. The medical profession in Connecticut now has the opportunity to use the corporate setup to develop a better medical service and a better American way of life.

Any mention of taxes or law that appears in this address is illustrative only and is not intended to take the place of the authoritative advice that only your attorney can give.

DISCUSSION

At the conclusion of the talk, the following question was asked the speaker by several of the doctors present. Because the subject is of interest to all doctors and professional men, I am repeating the question and answer below.

QUESTION

What do you think the chances are of the United States Congress passing a law that would permit doctors and other professional men to take an income tax deduction on contributions to a retirement fund?

ANSWER

Bills on this subject have been introduced into United States Congress several times in the past ten years. At the present time there are two bills that I know of which are being considered by the House Ways and Means Committee. These bills, which were introduced last June, are HR4371 and HR4373. If enacted into law they would give doctors, lawyers, accountants, partners, proprietors and other self-employed people a chance to build their own retirement income on a favorable tax basis, similar to that enjoyed by employees under plans qualified under section 165(a) of the Internal Revenue Code.

Briefly, these bills would permit persons in the categories listed above who are members of business or professional associations that have set up "a restricted retirement fund" for its members to make contributions each year of an amount not exceeding $7,500 or 10 per cent of the earned net income, whichever is the lesser. The ceiling on contributions would have to be reduced by any amounts contributed by an employer for the individual under a plan or trust qualified under section 165(a). The amounts deposited would be excluded from the gross income of the individual in the year paid into the fund up to the amount permitted. Thus the contribution would be paid in pre-tax dollars rather than in after-tax dollars.

The individual could not withdraw from the fund prior to age 60 except in the case of total and permanent disability. If he should die before withdrawal, his funds would go to his beneficiary. Distribution to the individual or his beneficiary could be made in one or more of the following three ways.

1. In a lump sum, in which case it would be taxed as a long-term capital gain with no reduction for the amounts deposited by the individual.

2. In annual installments over a period of years, in which case amounts received would be taxed as ordinary income.

3. In the form of a life income under an annuity contract purchased for the individual by the trustee, in which case amounts received would be taxed as ordinary income to the recipient in the year received.

The term "restricted retirement fund" means a trust forming a part of a retirement plan set up by a bona fide, agricultural, labor, business, industrial or professional association or similar organization for the exclusive benefit of its participating members for the purpose of distributing to such members or their beneficiaries the corpus profits and earnings of the trust, accumulated by the trust, in accordance with the plan. The trustee would have to be a bank and trust investments would be limited to "legals" which in Connecticut includes life insurance and annuities.

Obviously if a law of this kind were passed, it would eliminate part of the discrimination against doctors and other professional men which presently exists. As pointed out before, an executive of a corporation with a qualified pension trust can have a pension built for him out of non taxable dollars, whereas the doctor has to pay a tax on his dollars and then contribute what is left over.

The result of such a law for doctors would be the same as that for the executive of a corporation, namely to accumulate tax-free dollars during the high earning productive years for old age security and then distributing them during the years after retirement when income has dropped down and taxes are in a lower bracket.

As to whether such a law will be enacted, I would not want to venture a guess. If we consider what has happened to similar bills in the past, then there would not seem to be much hope. However, as taxes mount, the pressure for such relief increases and the discrimination against doctors and professional men, as compared with employees of a corporation with a qualified pension trust, becomes more pronounced.

STATEMENT OF THE PRESENT SITUATION AS REGARDS THE DOCTORS' DRAFT

Samuel C. Harvey, m.d., *New Haven*

The Author. *Chairman, Connecticut State Advisory Committee to Selective Service*

The first registration under Public Law 779, that of October 9, 1950, involved those physicians, dentists and veterinarians who had governmental support for their professional education or deferment from draft for the same reason and had had less than 21 months of service in the Armed Forces as doctors. Immediately Selective Service, which had this responsibility, began calling up such registrants, first those having had less than 90 days in service who were therefore in Priority I. This was urgently necessary because of the rapid expansion of the Armed Forces following the Korean incident. As to September of this year (1952) there were, including graduates of 1951 and 1952, approximately 200 of these in Connecticut of whom about 25 per cent were not acceptable to the Armed Forces. Of the 75 per cent acceptable, about two-thirds are in the Armed Forces and one-third (one-half of which have been classified as essential, for the most part as one year interns) are available for draft.

Thus, Priority I is at the present moment rapidly approaching exhaustion and Priority II will soon be so likewise for there are something under twenty available. These two priorities then have served, together with the calling up of reserves who had under 21 months of service, chiefly in the Navy, to meet the expansion of the Armed Forces over the past two years, but these reserves also will probably be exhausted by the coming March. Inasmuch as Public Law 779 specifically limits the time of service in the case of doctors to 21 months, an increasing number of these physicians are at the present time returning to civilian life, and it is estimated that it will require around 5,000 physicians each year for their replacement.

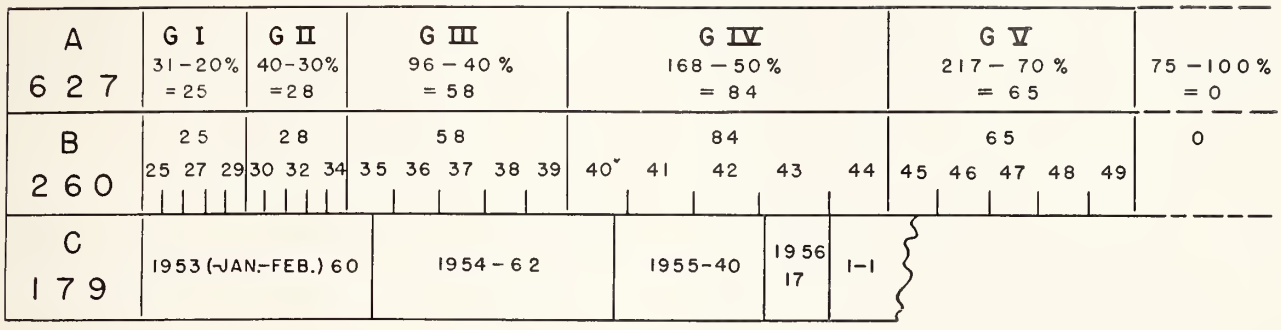
There are very few men in Priority I and II graduating from medical school at the present time, the training programs having been abolished in 1945. Apparently then, replacement will necessarily come from the second registration of January 16, 1951 which comprised those doctors up to 50 years of age who had not received governmental support or deferment for their professional education. In this those who served in the Armed Forces after 1940 at any level are classified as in Priority IV while lack of such service places them in Priority III. This latter priority must be exhausted before those in Priority IV can be recalled to active duty.

In Priority III there are some 32,000 physicians at the national level and 654 in Connecticut, or slightly over one-third of all physicians registered in this State.

If the national requirement is 5,000, then the call up at this level will be in the order of 417 per month, or for Connecticut about 2 per cent of the overall, that is to say 100 per annum or 8 to 9 per month. There will be, however, a yearly increment of medical school graduates available on the completion of one year internship which will increase nationally from around 6,200 in 1952 each year to something over 7,000 in 1956. These graduates on registration, which is obligatory, will be classified in Priority III and with but very few exceptions declared non essential on completion of the one year internship. However, the class of 1952 that is available in 1953 has around 80 per cent veterans who will be classified in Priority IV, thus producing a material deficit in the availability of these graduates. This proportion drops rapidly, however, so that it becomes relatively small in 1956. It is this transitory deficit that has to be met from the present category of Priority III.

The call up of these will be by age, starting with the youngest; it is convenient for the purposes of this statement to break this priority down into groups as shown in the graph.

In this graph an attempt is made on the basis of present data to estimate the relative liability in Connecticut of a physician according to his age. This is not authoritative and should not be interpreted as



definitive, for there are many variables in this calculation and these may change as time goes by.

A—Group 1 for example gives the estimated number of physicians in the ages of 25-29, inclusive, as noted in the lower half of B. In each group in A the total number is given as well as the percentage of depreciation expected, and those available after deducting this.

B—Gives the relative number available in each group.

C—Gives the anticipated number each calendar year to be called by the Armed Forces to meet the deficit as explained in the text. The call is by age and monthly, the youngest being taken first. Priority I and II will probably cover the months of January and February of 1953 and the call up in Priority III will probably start in March.

By using the above table the physician in Priority III can get some idea of his liability in relation to his age. There are of course other factors by reason of which he may not be liable. The more common of these, over which the Advisory Committee has no jurisdiction, are physical or mental disability (IV-F), and hardship (III-A). In evaluating one's liability in these categories, one must have clearly in mind that the criteria for determining these are not the same for the commissioned officer as for the non commissioned personnel as drafted under the Act of 1942 or that of 1948. In measuring physical and mental disability, the rough yardstick is as to whether or not a physician has been able to carry on actively in civilian life with his professional functions. So it may well be that one who has been classified as IV-F under one of the draft acts will be found available as a medical officer under Public Law 779. Likewise under III A which has to do with hardship and dependents, financial hardship is not recognized save in extreme circumstances, inasmuch as it is assumed that the emoluments as a commissioned officer are sufficient to keep him free from extreme hardship. Likewise under only extreme circumstances will the number of dependents be recognized for a classification in III-A. It must be emphasized again that the Advisory Committee has no part in this and that the responsibility rests entirely with the Selective Service Boards.

The category of II-A has to do with the essentiality of the physician as regards his professional activities to the effect "that the health services rendered are or are not essential to the maintenance of the national health, safety and interest and his induction in the Armed Forces would or would not cause the health services of the community to fall below reasonable standards" in the community in which he practices. It is as to this and this only, that the Advisory Committee advises the Selective Service Boards; they may or may not, at their own discretion, follow this advice but they are obliged by Public Law 779 to obtain it before implementing the classification of II-A. The State Advisory Committee is responsible for this advice but relies heavily upon the local Advisory Committees which parallel the Selective Service Boards for information and judgment, by reason of which the final decision can be arrived at.

Many factors of varying importance enter into this. This is perhaps best illustrated by considering the physicians in Priority III by age groups.

GROUP 1

This comprises those up to and through 29 years of age being at the maximum five years out of medical school, and at the minimum less than one year. The last are recommended for classification as essential (II-A) for one year of internship and non essential (1-A) at the end of this time, for the reason that the Armed Forces require one year of internship before active service. Those two, three and four years or more out of medical school are for the

most part still in hospitals, obtaining further postgraduate training. For this they are not considered essential and can be so classified only on the basis of essentiality in respect to the care of patients in these institutions. Inasmuch as only a minority of the hospitals in this state are recognized as qualifying for resident training and some who are only so quite recently, the majority are functioning without residents and presumptively at a level at or above "reasonable minimal standards." It is therefore difficult to establish essentiality for those who are in postgraduate training above the one year's internship. Very rarely there is a physician who has finished his training, has been certified by his board, is in a "scarcity specialty" such as anesthesia, pathology and radiology, and is confining his practice to this specialty who cannot be replaced by a physician having adequate qualifications in the community concerned or by bringing such a one in from elsewhere. Those few who have started in practice have done so so recently that it would be very unusual for any of them to have become essential.

It is for these reasons that the "slippage"* in Group I should be almost completely in IV-F and is estimated to be in the order of 20 per cent.

GROUP II

Comprises those physicians aged 30 to 34, inclusive. These obtained their medical education without governmental support or deferment, and for one reason or another did not have service in the Armed Forces. The majority have been in active practice under five years, and as in Group I, with the same reservations, will not have firmly established their essentiality. Some of these were classified as IV-F under the standards obtaining previously but on examination now will be held acceptable. Therefore, the "slippage" in this group is estimated at 30 per cent.

GROUP III

Comprises those physicians aged 35 to 39 inclusive. These for the most part had their medical education in the five years before 1942 and were therefore not by reason of governmental aid or deferment for this, subject to classification in Priority I or Priority II. By reason of their age they were not vulnerable under the Draft Act of 1942. However, they might have been expected, having so recently graduated, to have volunteered for service in the Armed Forces. Many have been in practice from 10 to 15 years and have become well established. They are, however, definitely vulnerable under Public Law 779 and essentiality must be based strictly upon its definition. It is anticipated, however, that there will be some increase in the category of IV-F and mainly for this reason the "slippage" is estimated at 40 per cent.

GROUP IV

Comprises those physicians aged 40 to 44 inclusive. These are in general in the same situation as those in Group III, save that there has been time for many of them to become well established in practice. Some of them may have been considered essential during World War II. These, however, must now be re-evaluated in this respect when and if it becomes necessary to call up those in this group. Returning veterans in some communities may well serve to maintain the minimum standards required. However, non acceptability by the Armed Forces by reason of physical and mental disability relative to their requirements may increase rapidly over 40 years of age. Therefore the "slippage" in this group is estimated at 50 per cent.

GROUP V

Comprises those physicians aged 45 to 49, inclusive. The same qualifications obtain here, but undoubtedly the acceptability by the Armed Forces will be materially lower. Therefore the "slippage" is estimated at 70 per cent.

GROUP VI

Comprises those physicians aged 50 to 51 inclusive. It is safe to say that none of these are acceptable by the Armed Forces at the present time and will not be in the future short of "total war."

The statements and opinions expressed herein are those of the writer, and are not to be construed as official or reflecting the views of the National Advisory Committee to Selective Service, or of Selective Service, or of the Armed Forces.

*"Slippage" may be defined as the differential between the theoretical potential availability and that deliverable.

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

EDITORIAL BOARD

STANLEY B. WELD, *Editor-in-Chief* - Hartford
HERBERT THOMS, *Literary Editor* New Haven
HAROLD S. BURR - - - New Haven
FRANK STAFFORD JONES - - - Hartford
MARSHALL C. PEASE - - - Ridgefield
E. CLAIR RANKIN - - - Hartford

Fairfield: Edwin R. Connors, *Bridgeport*
Hartford: Alfred L. Burgdorf, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Mark Thumim, Middletown
New Haven: J. C. F. Mendillo, *New Haven*
New London: A. Duncan MacDougall, *Groton*
Tolland: Ralph B. Thayer, *Somers*
Windham: Walter Rowson, Jr., *North Grosvenordale*

EDITORIALS

Pledge and Performance

The health platform plank of the Republican Party deserves reconsideration, for it states clearly and unequivocally a position to which the doctors of this nation can give wholehearted support. It reads: "We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital and the voluntary health insurance. We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight and debased standards of medical care. We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

On November 4 the people of this land voiced more genuine support of the president-elect than has been heard for many years. Few presidents have had so clear an expression of choice from so many divergent groups. Because of this we have every right to look hopefully to the majority party in the new government to put into action those changes in the administration of government which they have advocated.

It is in the field of social and welfare problems that medicine has its greatest interest, for it is in this area that doctors are becoming more and more involved. As doctors we must be willing and eager to shoulder these increasing responsibilities and continue to emphasize our belief that the primary aim of social security must be to create better health conditions of living: that is, with regard to housing, nutrition, clothing, recreation, and working conditions. No group of our citizens has a more intimate contact with health conditions and the experience of physicians should be of highest value to the planners and administrators of social programs having such aims.

As citizens and doctors we must be earnestly determined to do our part. We must choose for leadership in our own ranks men whose qualifications for such position include broad vision and sound reasoning, men who have an understanding of those principles in our American tradition of government which are fundamental in the national life of our people. One of these social beliefs is that assistance through agency aid should be given only to those who need it and those who do not should be given encouragement and opportunity to make provision for themselves, either through thrift or through voluntary insurance. We believe that such doctrine is found in the aims of those who have been chosen as our leaders in government for the next four years.

The planning of the future of our Society can never be ended. In this consideration we cannot be better guided than by the wisdom of Woodrow Wilson, who said:

"The history of Liberty is a history of limitations of governmental powers, not the increase of it.

When we resist, therefore, the concentration of power, we are resisting the processes of death, because concentration of power is what always precedes the destruction of human liberties."

The House of Delegates

The importance of the House of Delegates in the conduct of the affairs of the Society is obvious and the duty of each Delegate is demanding and serious, for he must have knowledge of affairs in order to give mature judgment. His election to office is one of honor for it is representative of the esteem and confidence that have been given to him by his fellow physicians. The privilege of free discussion which has always characterized our assemblies is recognized as basic in the society in which we live, and in this society to which we belong.

This year the principal item on the agenda will be the adoption of the budget for the ensuing fiscal year. This budget which has been prepared by the Council, as the Finance Committee of the Society, is presented to the House of Delegates for approval. Based upon that budget the Council recommends the amount of per capita assessment.

The expenditure of the funds of the Society is each member's business. How good our housekeeping is finds reflection in the report of expenditures and in the proposals of the budget. The House of Delegates is the final judge. In order for this House to function to its best efficiency, each Delegate should be in his seat at the initial sound of the gavel.

The George M. Smith Book Fund

Members of the Connecticut State Medical Society and of the Yale School of Medicine have established a Book Fund as a memorial to Dr. George Milton Smith, one time president of our Society and for many years a member of the faculty of the School of Medicine. Among the fields in which Dr. Smith was eminent was Occupational Medicine. It was through his influence and guidance that was established the Yale Institute of Occupational Medicine and Hygiene. The income of this Fund will be used to purchase books relating to these fields, to be placed in the Yale Medical Library with a suitable bookplate. Dr. Smith's interest in literary aspects of the fields in which he worked is well remembered. He was an ardent book collector and many of his valuable collections are found in the Yale Medical Library. This type of memorial would be one of his choice. The need is great for augmenting the Library's present holdings in occupational medicine and hygiene. Contributions may be sent to Dr. J. Wister Meigs, 333 Cedar Street, New Haven, made payable to Yale University for the George M. Smith Book Fund. Such gifts are deductible for tax purposes.

Trinity's New Library

Trinity College, training ground for many a future physician, proudly exhibited its new $1,210,000 library to the public on November 8. The formal dedication ceremonies, held outside in the breezy courtyard of the new building, marked the climax of two years of effort which finally brought together under one roof the Trinity and the Watkinson libraries.

Built of Colonial brick, the entire building is impressive in its beautiful simplicity. It is equipped with a spacious reading room lighted by overhead Neons, twenty-two small study rooms, a few larger conference rooms, and ample stack space for several years to come.

President Cole of Amherst College was the principal speaker at the dedication ceremonies. "So central is a library in higher education," said President Cole, "that it is impossible to exaggerate its importance." "A college," he went on, "can dispense with practically every other feature, from its swimming pool to its faculty, and yet turn out educated young men so long as its library functions."

With the academic gowns of the faculty blown about by the raw November wind and the picturesque hats of the trustees commanding the eye of every visitor, it presented a striking and colorful scene. We salute Trinity College and congratulate it on arriving at this another milestone in its educational progress.

It Is Too Easy to be a Member of a Medical Society

When a physician becomes a member of his local medical society, he is thereby granted certain privileges for a lifetime; to practice and enjoy the benefits and protection of an organization whose history is replete with sacrifice and whose glory is in its constant endeavor to improve its services to mankind.

What does the average man in medicine give in return for the privilege of membership in this great

and honorable profession? Unfortunately the only obligations assumed by a young doctor on election to his society are ethical conduct and the payment of dues.

Doctors must pay with far more than just dues if they are going to be useful members of their medical societies. They must serve.

The preservation of the rights of the profession and the advancement of scientific attainment is a problem that needs and deserves the active participation of every member.

Membership in the local society is a prerequisite to (1) membership in state and national associations, (2) membership in specialty groups, and (3) membership on hospital staffs.

It is obvious that if membership is so eagerly sought after in the higher echelons of medicine, then the attainment of membership in the local society, which is a prerequisite to membership in the higher echelons, should not be so lightly taken as it is by some men.

It is evident that a longer probation period, possibly one year with courtesy privileges, should be a prerequisite to membership in a local society. During this period, the candidate should be required to attend at least three-fourths of all stated meetings as evidence of good faith and to acquaint himself with the personnel and procedures of the society.

The minimum requirement for renewal of membership in the local society at yearly intervals should be attendance of at least one-third of the stated meetings of that society. (We could take a tip from the Rotary Club which does not tolerate lax attendance.)

Perhaps membership in organized medicine is too easily obtainable.

Jl. Tenn. State Medical Assoc., April, 1952

Participating Physicians in CMS

There are many aspects of Connecticut Medical Service which have been extremely gratifying to Connecticut medicine since the program was established in April 1949. During 1950 it became known as the "fastest growing plan for surgical care in the United States." On May 15 of this year it celebrated the enrollment of its 500,000th member, and became at that time the twelfth largest Blue Shield Plan in the country. It has continued to achieve new records and current statistics show that it is now the tenth largest plan in the country, having acquired 92,000 members since the May 15 celebration. For the first six months of 1952 it was the first plan in percentage growth for that period. With a current membership of 592,000 it is now the fourth plan in the country in percentage enrolled of the population covered by the plan; 28.92 per cent of the Connecticut population are members of Connecticut Medical Service.

All of these economic statistics indicate the great need there was for a plan such as CMS and the payment figures of over $8,000,000 in the three and a half years of its existence indicate the major part it is playing in paying the cost of surgical care for a substantial part of our population. There is no statistic, however, so important to the future of organized medicine as the degree of participation by Connecticut physicians in their plan. With the advent of the in-hospital medical care program on June 1 of 1952, participation in CMS received a new impetus. It was the first time that many practitioners (those engaged in internal medicine, pediatrics, and similar non surgical practices) could become Participating Physicians with any expectation that their patients would receive CMS benefits. Since June 1, 216 new Participating Physicians have been added to the CMS roll. At this writing, there are 2,018 Participating Physicians in Connecticut. As far as can be determined by the CMS Home Office and the Connecticut State Medical Society approximately 80 per cent of all practicing physicians in Connecticut are Participating Physicians in CMS. Resignations from physicians who have disagreed with professional policies or the fee schedule have been negligible with only 38 Participating Physicians having resigned since the plan began; 62 resignations were due to leaving the state, deaths, or retirement from practice.

There can be no question that, with the continued increase in the number of Participating Physicians in CMS, and the splendid practical contribution it is making to help Connecticut people meet the costs of good health care, the future of CMS is bright indeed.

The Lesson of Shangri-La

"Abuse of anything does not abrogate the lawful use thereof."

Old legal maxim quoted by
Sir Robert Bruce Lockhart

The individual who originated the cliche "more truth than fiction" doubtless was thinking of fiction in the sense of "what is imagined or made up"

rather than in that of "writings that tell about imaginary people and happenings." As a matter of fact novelists have written novels with a purpose probably as long as such literature has existed, notably Charles Reade among the English speaking peoples. Since reading Hilton's novel "Lost Horizon" I have often felt that though it probably was not written with a definite purpose, it was a good book to "read, mark, learn, and inwardly digest," because the main theme of that part of it which deals with the monks of Shangri-La and their associates is the importance of moderation in all things.

Prominently featured on the front page of a recent newspaper was a box headed "Long Vacations, Daily Drink, Proposed for Businessmen." It states that Dr. Sara M. Jordan, the well known gastroenterologist of the Lahey Clinic, heartily recommends tired businessmen over 50 to get the habit of taking one or two drinks a day because of their relaxing effect. It is perfectly clear what Dr. Jordan is aiming at, namely, a life of moderation, for she suggests also two month-long vacations a year, a slowing down of the pace of living and a nap after lunch. All of which is really very sensible, but we fear that the good doctor will begin to experience some of the excoriations which political candidates undergo in the race for their particular goal, namely, her aims will be distorted by captious and not too scrupulous critics, especially her statement regarding the advisability of alcoholic drinks. These well meaning but astigmatically minded reformers are not really interested in temperance but in total abstinence.

The chief difficulties lie no doubt in defining moderation and also in the variable effects of alcohol on different people. Those who have read Marion Sims' autobiography will recall that the eminent pioneer gynecologist records that one night he went out with the boys, had one drink of sherry, and had to be carried home on a shutter. Obviously he was one of those rare people who are so hypersensitive to alcohol that they cannot touch it. Then again it is well to remember that among alcohol users there is a group, statistically one out of 5, who are like that celebrated Frenchman who could resist everything but temptation. In a word there are a goodly number of drinkers who seem constitutionally unable to stop at one or two drinks and apparently can never use alcohol in moderation. It should be noted, however, that Dr. Jordan's advice is given to men over 50, and it is highly probable that if a man has an inclination to use alcoholic liquors he will have begun before that age and it will have become evident whether he belongs to the unfortunate 20 per cent who cannot drink in moderation. As a matter of fact even moderate drinkers may occasionally get into trouble, for susceptibility to the effects of alcohol, a narcotic, vary from time to time in the same individual. More recently in the same newspaper Dr. Andrew C. Ivy, a well known physiologist, is reported to have called attention to the already quoted fact that one in five drinkers eventually become problem drinkers and to have suggested as a solution to the problem a return to prohibition. The good doctor is evidently unaware of Santayana's dictum: "those who cannot remember the past are condemned to repeat it." Indeed he need not even trouble to recall the hypocritical prohibition era with its bootleggers, its homebrewers, its hijackers, its poisonous alcoholic compounds, its smugglers, its great increase in illicit stills, for all of these have again appeared within the last year or two because the government put too high a tax on distilled liquor. If Dr. Ivy had taken the trouble to search the records of history he would have found that exactly the same thing had happened before under excessive taxation. The prevention of the excessive use of alcohol does not lie in legislation but in education. The problem is indeed a difficult one and may perhaps be insoluble in some, but certainly not in all problem drinkers.

G. B.

Dr. Plunkett Appointed Secretary of Committee on Mental Health

Richard J. Plunkett, 43, of Winnetka, Illinois, has been appointed secretary of the newly established Committee on Mental Health of the American Medical Association. The appointment was made by the association's Board of Trustees. Dr. Plunkett has been a member of the AMA's editorial staff for the last five years.

The committee, established in March 1952 was formed primarily to consider problems that exist today in psychiatry and mental health.

Dr. Leo H. Bartemeier, Detroit, is chairman of the committee. Other members are Drs. Lauren H. Smith, Philadelphia, vice-chairman; Walter H. Baer, Peoria, Illinois; Hugh T. Carmichael, Chicago; Francis M. Forster, Washington; M. Ralph Kaufman, New York, and Maurice Levine, Cincinnati.

REMARKS OF VERNON W. LIPPARD, M.D.

The Author. *Dean, Yale University School of Medicine*

It is most appropriate that my first public appearance be made at the Connecticut Clinical Congress where the physicians of the State and the faculty of the Medical School are joining with a common purpose of improving the health and medical care of the people in this area. I can assure you that nothing is closer to my heart than the desire to aid in the mutual understanding which will lead to achievement of this goal.

I realize that the mutual understanding between the Yale School of Medicine and many of the physicians in Connecticut may not be as natural as it is between the university and physicians in such states as Virginia and Louisiana where half of the practitioners wear the same old school tie. That can never be true in an area where within a radius of about 150 miles, there are 11 medical schools. Perhaps the best answer is that each of you here this evening, those who have attended the Congress last year and those who will attend it in the future consider yourselves not only alumni but active students in the Yale School of Medicine. After all, your medical education only begins when you receive your diploma and we should like to have you look upon the School and the Grace-New Haven Community Hospital as the center to which you can turn for continued education and for other assistance which will make it possible for you to provide better medical service.

I must confess that this evening I have many sensations in common with the prodigal son, as I am returning home after these 23 years and returning, with a most sincere desire to contribute, in some small way, to the institution which did so much for me. It is reported that the fatted calf is not too obese and some would say that it would be more fitting for me to use another bovine analogy and say that I had a bull by the tail. Let me say at the outset that I am definitely not of that opinion. If I did not believe that the School has not only great assets but also great potentialities, I would not be here.

I have had an opportunity, over the past 20 years, to look upon the Yale School of Medicine as an outsider. I have seen it rise from a comparatively obscure institution which made a very small contribution to the nation's health to one of the 3 or 4 outstanding medical schools in the nation and one whose excellent reputation is known in every country in the world. Its graduates and faculty have become leaders in many fields of medical science and its research is recognized widely to be of high quality.

The School has certain unique characteristics. It offers an intellectual discipline difficult to achieve when mass production is the primary goal—an atmosphere in which eager students, whose minds are capable of stretching, may extend beyond the limits of the standard textbook. At least in my day as a student, it offered a congenial relationship between faculty and student which I have not found in most other schools. Such characteristics must be preserved in the face of expanding responsibilities. If real growth requires expansion, it is indicated, but I am not in favor of the type of expansion one sees in some educational institutions, merely for the sake of being big.

Certainly the School has its problems, but many of these problems it shares with every other medical school in the country. American medical schools have developed, over the past 50 years, from little more than trade schools to highly complex institutions with responsibilities for education of physicians and other health personnel, for most of the basic research which has led to such significant improvements in health and for some aspects of medical service.

All this has cost money. Funds for research have become available beyond the dreams of the most avaricious dean of a generation ago. But research cannot be conducted in a vacuum. To utilize research funds, investigators must be provided with laboratories, basic equipment and basic salaries.

Furthermore, we must not lose sight of the fact that the primary responsibility of an educational institution is education and a very fine balance of emphasis must be maintained. If instruction becomes a sideline and is not adequately supported in terms

Given at a Dinner for Dr. Lippard by the Connecticut State Medical Society, New Haven, September 17, 1952
Published in part

of interest and finances, we shall dry up the source of both good medical service and research.

The time has also arrived when the medical curriculum, in relation to the responsibilities of its graduates, can bear some careful scrutiny. Medicine as a science extends far beyond the boundaries of the human organism and should be concerned with everything that touches upon health. Greater emphasis must be given to the stresses resulting from social and emotional influences. We must be as concerned with the emotional and social implications of an amputation as we are with the histological characteristics of the neoplasm which indicated the necessity for the operation. This change will not be brought about by radical surgery on the curriculum but rather by a change in attitude. A by-product of this change will be an increasing emphasis on outpatient instruction and decreasing emphasis on the "interesting case." Of course, the pendulum must not be allowed to swing too far. It would be equally ridiculous to produce physicians so concerned with the emotions that they lose interest in the structure and function of the human body and the mechanisms of disease.

Serious thought must be given to the role of the medical school in relation to the overall function of the University. Historically, many British and American medical schools have developed essentially independent of their parent universities, with duplication of departments and an unhealthy absence of common interests. Yale is in a strategic position to assume the leadership in the solution of this problem.

This same lack of communication has unfortunately existed between the medical profession and many medical schools. Organized medicine has been negligent in its support and encouragement of medical education. On the other hand, it is only fair to say that many deans and faculty members have lost sight of the goals and objectives of the practitioner.

The most encouraging development in this area over the past several years is the organization of the American Medical Education Foundation. I am optimistic that this organization, controlled and supported by the medical profession, will become a major source of support of the medical schools but even if its contribution in terms of dollars is not great, it will have accomplished a great deal in interpreting to the profession the needs and problems of medical education. In reverse, it may aid in convincing those of us who are not intimately concerned with practice that we are all in the same boat and that improvement in the health and well-being of the people can best be achieved by preserving the freedom essential to maintenance of high standards of medical service. We must be very careful, however, to see that this freedom is not abused. All these problems lie before us.

I did come here with the intention of conveying to you one message. That message is that, in taking over responsibility for administration of the Yale School of Medicine, I have an earnest desire to work closely and harmoniously with the physicians of the State.

Launch 5 Million Dollar Medical Education Campaign

The National Fund for Medical Education, with offices in New York, is launching a five million dollar industry-wide solicitation campaign in support of medical education in the United States.

Colby M. Chester, newly appointed chairman of the fund's Committee of American Industry, will direct a nationwide organization to mobilize business concerns behind the nation's hard-pressed medical schools. Mr. Chester is honorary chairman of the board of General Foods Corporation.

The National Fund for Medical Education is a lay organization which is working in conjunction with the American Medical Education Foundation, founded by the American Medical Association two years ago. The AMEF's goal for 1953 is included in the five million dollars.

The National Fund's Committee of American Industry, which will spearhead the campaign, will be composed of 100 ranking business leaders from every segment of industry. Their task will be to educate industry as to the critical needs of the medical schools. The committee contemplates solicitation of 25,000 American business concerns during 1953. Mr. Chester plans to appoint a vice-chairman, an advisory council, and division chairmen, who will direct the activities of more than 50 industrial committees. E. J. Ade, New York, has been appointed fund raising director for the campaign.

PROGRESS IN CLINICAL MEDICINE

LESION IN AND ABOUT THE SECOND PARTITION OF THE DUODENUM

N. B. Jaffe, M.D., *Bridgeport*

The small intestine is a complicated tube, with its greatest circumference at the duodenum, tortuous, 22 feet 6 inches, to 31 feet 10 inches in length, divided into duodenum and the jejunoileum. Its structure, anatomy, vascularity, innervation, glandular components, histology and physiology are extremely complex. It is the seat of food absorption.

The duodenum, following the pylorus, forms a circle. According to Piersol it may be v-shaped, ring-shaped, intermediate, c-shaped, or unclassified. The length of the duodenum is about 10 inches. The first part measures 5 cm.; the second, 8 cm.; the third, 6 cm.; and 4th, 7 cm. The two largest circumferences are in the second part.

The second part descends vertically forming an acute angle with the first. It lies on the right side of the vertebral bodies beside the vena cava and behind rests on the right suprarenal capsule and kidney, the renal vein and the ureter. It lies on the right against the ascending colon, on the left side against the head of the pancreas. The bile duct runs along the left side and passes obliquely through the intestinal wall.

This intestinal loop, circling in midst of vital organs, has been more or less a terra incognito, an area of fanciful hypothesis, a circle of potent pathological possibilities. Only recent ingenious x-ray techniques and necropsy researches have penetrated to a certain depth into the sphere of diagnosis.

The second portion of the duodenum lies retroperitoneal and is also known as the descending or vertical portion. It extends from the neck of the gall bladder and the level of the first lumbar vertebra downward along the right side of the vertebral column, as low as the upper border of the fourth lumbar vertebra. It bears a fairly constant relationship to several important anatomical structures in this region, and because of this, a careful study of the second portion of the duodenum in obscure lesions of the upper abdomen may prove of very definite diagnostic value. All too frequently the bulk of the examiner's attention is focused upon the stomach and first portion of the duodenum, the so-called cap and bulb, with only a cursory glance being given to the opaque column as it passes downward into the second and third portion of the duodenum. The diagnosis of many lesions in this area is thereby missed or delayed beyond hope of cure.

It should be self evident that no intelligent interpretation of changes involving the second portion of the duodenum can be made without a knowledge of the anatomy of this region and the structures that come into intimate relationship with the duodenum. It is likewise axiomatic that adequate x-ray examination in this portion of the duodenum requires the use of negatives made in the right oblique and right lateral projections as well as the posterior-anterior view. The superior flexure of the duodenum, which is that portion immediately beyond the bulb, is in relationship anteriorly with the gall bladder and cystic duct, posteriorly and superiorly with the hepatic ducts, posteriorly with the common bile duct and inferiorly and medially with the head of the pancreas. The extra hepatic biliary tract forms a flexible ring around the superior flexure of the duodenum, with the lower portion of this ring embedded in the head of the pancreas.

In its middle third, the second portion of the duodenum is crossed by the transverse colon and above this it is in contact with the right lobe of the liver and posteriorly it lies in contact with the right kidney in the region of the hilum, medially as we have mentioned, with the head of the pancreas and the common bile duct.

Diverticula of the duodenum are relatively common and probably represent the largest group of any congenital abnormalities of this portion of the intestine. In 1927 Larimore and Grand discussed diverticula and duplication of the duodenum and felt the majority of the duodenal diverticula could be classified as acquired. These may either be true or false diverticula. The true diverticula contain all

layers of the intestine. The false lack the muscular layers. Weakness at the site of entrance of vessels or ducts through the duodenal wall and inflammation are some of the factors suggested as causes of acquired type of diverticula. Redundancy of the second portion of the duodenum was noted by the author and has been noted by others on numerous occasions. It must be differentiated from diverticula of the duodenum and from changes in the normal duodenal contours due to pressure of extrinsic structures. The majority of the duodenal diverticula probably produce no particular symptoms. However, one sees an occasional diverticulum which retains the opaque medium over a much longer period of time than normal, with irregular walls and the patient complaining of definite pain and tenderness on pressure over the lesion. Such diverticula may be presumed to be symptom producing if one has carefully ruled out all other causes of pain in this area. Chief among these is chronic cholecystitis.

Duodenitis appears to be a definite entity which most authors find to be largely limited in the cap of the duodenum and which many feel is an antecedent lesion to duodenal ulcer. However, duodenitis does not occur in the second portion of the duodenum and the findings in this area are quite similar to those seen when it involves the cap. Sussman, in describing this lesion, mentions the abnormally increased irritability of the duodenum. This is manifested by extreme spasticity and hypermotility of the opaque medium in its passage through the duodenum. The mucosal pattern is rather coarse and irregular. An ulcer crater is not demonstrable and obstructions do not occur. At times, duodenitis associated with a coincident duodenal ulcer may be present.

Postbulbar duodenal ulcer has been stated to be at least as common as gastric ulcer. The characteristic sign of the postbulbar ulcer is the niche defect. Pain is a common symptom. Bleeding is three times as common as in ulcer of the duodenal cap. These lesions are small and easily missed and careful study of the second portion of the duodenum should be made in all cases of obscure upper gastrointestinal tract bleeding.

Retroperitoneal rupture of the duodenum may occur with trauma of the abdominal wall. The mortality resulting from this lesion is quite high. An early diagnosis is of extreme importance. Sperling and Wrigler reported a case in which the diagnosis was made by visualization of gas in the retroperitoneal area about the right kidney. The appearance of gas in this area is rather characteristic and is almost pathognomonic of retroperitoneal rupture of a hollow viscus. Perforation of the second portion of the duodenum may also occur during operative procedures in the right kidney, common bile duct or head of the pancreas. Foreign bodies have been reported as becoming impacted in the duodenum, although most of these lie in the first portion. Not uncommonly one sees a fistulous connection between the duodenum and biliary tract with passage of air into the gall bladder and hepatic radicals which is demonstrable on the plain film of the abdomen. Subsequent examination with an opaque medium will usually reveal the abnormal tract. Such fistulas in many cases are associated with gall stones which have eroded through the gall bladder wall and may produce intestinal obstruction at the ileocecal valve. Demonstration of gas in the hepatic radicals may prove to be a valuable clue to the etiology of obstruction in cases of nonopaque calculi.

Congenital duodenal obstruction is uncommon and there may be complete atresia or varying degress of stenosis or diaphragm formation. Vomiting occurs very early in life, differentiating this lesion from pyloric stenosis.

Another cause of duodenal obstruction is annular pancreas, the site of obstruction being in the distal part of the second portion of the duodenum. Malignant lesions of the duodenum are the most frequent of malignancies of the small intestine. Carcinoma of the second portion of the duodenum usually occurs at or above the ampulla of Vater. Distortion and destruction of the mucosal pattern are important in making the diagnosis. Carcinoma and stones occurring at the ampulla of Vater must be differentiated from ectopic pancreas. A space occupying expansive intraduodenal process caused an intraduodenal filling defect which in contrast to that caused by an extraduodenal process, is consistent in form and demonstration. Winthrop and Duddle, in discussing neoplasm involving the duodenum, reviewed 20 cases, 4 of which had primary carcinoma of the duodenum, 2 were carcinoma of the ampulla of Vater; all of the primary malignancies of the duodenum produced filling defects with varying degrees of obstruction and the normal pattern of the mucous membrane was destroyed. A fistulous connection between the duodenum and the biliary tract was found in one case. The authors feel that neo-

plasm should be suspected when this is seen. The combination of rapidly deepening jaundice, dark blood in the stools and x-ray evidence of a lesion in the region of the ampulla of Vater should certainly make one suspect a possibility of a carcinoma of the ampulla.

Benign tumors of the duodenum are rare but do occur. Dilatation of the extra biliary tract due to obstruction, stone, tumor or extrinic mass causes a pressure defect on the superior flexure of the duodenum. This has also been described as a bandlike depression which crosses the duodenum in the region of the tip of the bulb or the upper horizontal part. This bandlike depression is felt to denote dilatation of the common bile duct and mostly results from a block in the region of the ampulla. However, this pressure defect has also been seen as resulting from dilatation of the cystic duct. Brown has reported it occurring with dilatation of the hepatic ducts. This is an especially important sign when one attempts to differentiate films made in the right oblique, and right lateral projections are essential. In many cases showing dilatation of the common bile duct, cancer of the head of the pancreas is the cause of the obstruction. In addition to the signs of dilatation of the extra hepatic biliary tract, one should look for widening of the duodenal loop with the displacement of the second portion of the duodenum posteriorly or pressure defects on the greater curvature of the stomach in the region of the antrum and prepyloric area.

The widening of the duodenal loop is in contrast to the changes in its position produced by regions of the retroperitoneal structures rather than the pancreas. Lesions of the right kidney may displace the second portion of the duodenum forward and to the left. Enlarged lymph nodes may produce a central filling defect, and in some cases a combination of depression and invasion of the loop may occur. Such changes suggest invasion by multiple destructive processes. Most of the lymph nodes involved in this area are metastatic in character, although primary tumors of the nodes do occur and primary lymphosarcoma of the duodenal wall has been reported. A space-filling extraduodenal expansive process causes displacement and inward depression of the duodenal loop, at times with partial stenosis. An even smooth depression favors the presence of a cystic or compact process. A space occupying process which presents principally the signs of an expansive growth and little destruction in the duodenal loop suggest invasion of the duodenal wall by extra duodenal tumor, primary or secondary. An extra duodenal inflammatory process may produce changes like duodenitis. In acute pancreatitis, a persistent spasm may be present with or without contour changes. In other cases, widening of the duodenal loop, flattening of the mucosal folds and the inverted 3 sign may occur. We have found the changes in the second portion of the duodenum to be of great value in the differential diagnosis of lesions producing jaundice. In malignant tumors of the pancreas, whether involving the head or the body, we noted a non functioning gall bladder is associated in a very high percentage of the cases. That is true even in people who do not exhibit jaundice. A broad smooth filling defect involving the superior flexure of the duodenum associated with slight to moderate jaundice, a non functioning gall bladder and a normally placed duodenal loop, is in many cases due to obstruction of the common bile duct by stones.

A rather uncommon lesion, but one which usually produces common duct obstruction and dilatation is primary carcinoma of the common bile duct itself.

In conclusion, a careful study of the second portion of the duodenum often yields a great deal of information about lesions of the upper abdomen and is particularly valuable in the differential diagnosis of lesions producing jaundice.

THE DOCTOR'S OFFICE

Alfred Kelly Bates, M.D. announces the opening of an office for the practice of medicine at 35 South High Street, New Britain.

Mark Conway, M.D. announces the opening of an office for the general practice of medicine at 387 Blue Hills Avenue, Hartford.

Walter P. Gerent, M.D. announces the opening of his office for the practice of internal medicine and cardiology at 271 Farmington Avenue, Hartford.

Harold Lipton, M.D. announces the removal of his office to 270 Farmington Avenue, Hartford.

Joseph A. Reynolds, M.D. has resumed practice at 18 Central Avenue, Waterbury.

A. Lewis Shure, M.D. announces the removal of his office for the practice of orthopedic surgery to 1175 Chapel Street, New Haven.

THE PRESIDENT'S PAGE

NURSE RECRUITMENT CAMPAIGN

A campaign for the recruitment of nurses has been opened in New Haven County and will be extended to the other counties of the State during the succeeding months. The shortage of nurses is an old story but is recognized by doctors to be a continued factor in the limitation of hospital activities. Many more hospital beds in the State would become available if additional nursing personnel could be obtained.

While the number of those entering training schools continues at the same level as in the past five years, the expansion of medical services, Blue Cross, hospital, medical and surgical insurance has been followed by an enormous increase in the use of hospitals and has created a nurse shortage which shows no signs of being relieved.

A committee of the American Medical Association for the Study of Nursing Problems under the chairmanship of Dr. Thomas Murdock has outlined a plan for increasing the number of nurses and this plan which includes the short term training of nurses aides, trained attendants and nurse technologists has already been adopted in some hospitals.

In Connecticut, during 1951, there were about 400 places in nurse training schools which were not filled. If this campaign for the recruitment of additional nurses is to be a success, those who direct it will try to determine what prompts a young woman to adopt nursing as a vocation. St. Camillus, who in the sixteenth century founded the first nursing order devoted exclusively to the care of the sick, wrote, "If wearily you do a good thing, the weariness passes and the good remains." Such a sentiment does not describe the daily routine of a student nurse in training today. However, repeated surveys have shown that the young women who take up nurse training are prompted in this decision by a spiritual objective and inspired by a spirit of service to others. Without this factor a nurse is incomplete. Nurse training today has achieved a high scholastic level, whether in college with the reward of a degree or in a diploma school of nursing. Much of the drudgery which tried the souls of young nurses in the past has been eliminated by modern technological improvements as well as by a division of labor. In Connecticut the State has established a generous scholarship program so that the financial burden on the family of the student is in part relieved.

Doctors have a lively appreciation of the importance of the nurse in the care of the sick and welcome the interest and effort shown by those directing the campaign to increase the number of nurses. Physicians have experienced a serious handicap in their work as a result of the shortage of nurses and are eager to aid in the recruitment program as individuals as well as through their medical organizations.

Edward J. Whalen, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
JAMES G. BURCH
Director of Public Relations
160 ST. RONAN STREET, NEW HAVEN
Telephones: UN 5-0587, LO 2-0836

HOUSE OF DELEGATES CALL FOR SEMI-ANNUAL MEETING

The Semi-Annual Meeting of the House of Delegates of the Connecticut State Medical Society will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Thursday, December 18, commencing at 4:30 o'clock in the afternoon. The purpose of this meeting is to pass upon the Society's budget for 1953, hear reports from the Professional Policy Committee of Connecticut Medical Service and the Committee on Mental Health and such other matters as may be presented.

Members of the House will be the guests of the Society at a buffet supper following the meeting.

Edward J. Whalen, President
Creighton Barker, Executive Secretary

Arthur W. Eade

The secretary wishes to express a sense of great loss in the death of Arthur W. Eade. He was a warm personal friend and for many years served the Society faithfully in handling its group health and accident insurance. Mr. Eade had unique interest in medical affairs, he was an honor graduate of the College of Pharmacy of Columbia University and for some time engaged in the practice of that profession. His respect for physicians and the ideals of medicine was very high. Arthur W. Eade, Jr., a graduate of Brown University and an ex officer of the USNR, was associated with his father and will continue operating the society's group.

Council Meeting

The October meeting of the Council was held at the offices of the Society on October 23, 1952. The meeting was called to order by the Chairman, Dr. Howard, at 4:30 P. M. There were present: Drs. Buckley, Couch, Danaher, Feeney, Fincke, Gettings, Gildersleeve, Howard, Labensky, Phillips, Root, Russell, Thoms, Tracy, Walker, Whalen, Barker. Absent: Archambault, Flaherty, Gallivan, Gens, Gibson, Murdock, Shepard, Ursone, Weld.

1. The resignation of Charles N. Sullivan of New Britain from the Committee on Public Health was accepted with regret and Edward T. Wakeman was appointed to fill the vacancy on the committee. Dr. Wakeman's appointment has been suggested by J. Harold Root, chairman.

2. The chairman appointed a Budget Committee to prepare the budget for 1953. The committee is to consist of Frank H. Couch, treasurer of the Society, chairman; Edward J. Whalen, president, and C. Louis Fincke, councilor from Fairfield County. This committee is to have its first meeting on November 5.

3. Certain over expenditures on the part of the Public Relations Committee, particularly relating to the American Medical Education Foundation, were discussed and it was voted that an extra allotment of $500 be made available to the committee to cover those over expenditures and expenses of the AMEF Campaign during the remainder of the year. The secretary reported that Connecticut ranks fifth among the states in the number of contributors to the AMEF and eighth in the amount contributed.

4. It was voted that the semi-annual meeting of the House of Delegates be held in New Haven on

December 18. Items for the agenda of the meeting were discussed and it was noted that the Committee on Mental Health and the Professional Policy Committee of the Connecticut Medical Service wished to report at that time. The president of the Society, the chairman of the Council, and the executive secretary were named to arrange an after dinner program.

5. Four matters in the insurance field were discussed.

a. The secretary presented a statement of increased rates for the Society's group professional liability insurance written by Aetna and stated the reasons why the premium increase was necessary. No action was required by the Council.

b. A proposal to extend the coverage under the present group health and accident insurance written by Commercial Insurance Company was discussed and it was noted with satisfaction that this Company was to reopen group enrollment in the Society contract.

c. A proposal for a supplemental group health and accident contract that had been submitted by the Mutual Benefit Health and Accident Association of Omaha was discussed and no action taken.

d. A proposal for life insurance coverage for members of the Society at group rates which had been received from the United States Insurance Company of New York was discussed and no action taken.

It was voted that the chairman appoint from the Council a Committee on Insurance and that the committee consider the matter included in c and d above and such other insurance proposals that may come before the Society. The chairman appointed to this committee Chairman Maurice T. Root, F. Erwin Tracy, and Alfred Labensky.

6. Thirty-nine student members were elected.

7. It was voted to pay the usual assessment of $75 to the Conference of Presidents and Other Officers of State Medical Associations and to contribute $100 to the Foundation for Economic Education and to ask the Foundation that its publications be sent to members of the Council.

8. Dr. Danaher reported informally and briefly concerning CMS Blue Cross relationships.

Society Dues

Total membership—January 1, 1952		2,728
Total exempt		168
Total billed		2,560
Fairfield County	49	
Hartford County	75	
Litchfield County	5	
Middlesex County	8	
New Haven County	35	
New London County	7	
Tolland County	1	
Windham County	9	
Total unpaid		180

AMERICAN MEDICAL ASSOCIATION DUES

Total membership—January 1, 1952		2,728
Total exempt		212
Total billed		2,188*

*Members who did not pay 1951 AMA dues were not billed for 1952 dues

Total unpaid		68
Fairfield County	17	
Hartford County	13	
Litchfield County	7	
Middlesex County	6	
New Haven County	18	
New London County	4	
Tolland County	0	
Windham County	3	

The above does not include the 95 new members who were elected in October 1952.

New Members

TOLLAND COUNTY

Deal T. Aseltine, Jr., Rockville

WINDHAM COUNTY

John B. LeRoy, Storrs
George C. Lincoln, Woodstock
Sherman L. Waldron, Thompson

HARTFORD COUNTY

George R. Andrews, Hartford
Edward R. Bagley, Hartford
Alfred K. Bates, New Britain
Alexander E. Bayer, New Britain
Robert K. Butterfield, Manchester
Salvatore R. Carrabba, Hartford
Sigmund E. Chessid, Newington
Charles H. Crothers, New Britain
Leo B. Drake, Hartford
William J. Dwyer, Bloomfield

Robert C. Emmel, Hartford
Dwight B. Fishwick, Rocky Hill
Gerald P. Fitzgerald, Hartford
Ludwig M. Frank, Hartford
Joseph R. Gionfriddo, Hartford
Archie J. Golden, Wethersfield
Philip T. Goldenberg, Hartford
Norman D. Gross, Hartford
William S. Hannan, East Hartford
Thomas H. Horrigan, East Hartford
George B. McAdams, Hartford
James F. McAndrews, Hartford
James M. McCormick, Hartford
Nicholas A. Marzialo, Manchester
Thomas J. O'Connell, Hartford
Orlando P. Orfitelli, Bloomfield
Joseph Platz, East Hartford
John A. Pierce, Hartford
William E. Purnell, Hartford
Raymond E. Schipke, Hartford
Edward Scull, Hartford
Lillian A. Smith, Hartford
William J. Stack, Hartford
William D. Stroud, Manchester

NEW HAVEN COUNTY

Frank K. Abbott, Waterbury
Lois D. Armbruster, Cheshire
Paul B. Beeson, New Haven
Philip K. Bondy, New Haven
Lawrence G. Crowley, New Haven
Ernest H. Ferrell, Jr., New Haven
Albert S. Field, Jr., Wallingford
Henry L. Francis, Waterbury
Edwin M. Fuller, New Haven
Robert S. Gordon, New Haven
Richard B. Harvey, New Haven
Thomas F. Hines, New Haven
Emil D. Karlovsky, New Haven
Ruth W. Lidz, Hamden
Theodore Lidz, New Haven
Bernard F. Mann, Jr., New Haven
Richard J. Newman, Waterbury
Francis H. O'Brien, Waterbury
Vincent Pepe, Wallingford
Earl J. Rhoades, New Haven
Sylvester J. Ryan, New Haven
Robert H. Sturman, Waterbury
Robert R. Wagner, New Haven

Meetings Held in November

November 5—Budget Committee
Executive Committee, Connecticut Heart Association
Governor's Commission on Medical Education

November 6—Council- Sub-Committee on Insurance
Sub-Committee on School Health
Medical Advisory Committee, Connecticut Cancer Society

November 10—Joint Conference Committee with the Connecticut Pharmaceutical Association

November 12—Governor's Commission on Medical Education
Committee on Maternal Mortality and Morbidity

November 13—Executive Committee, Connecticut Heart Association
Committee on Public Health

November 19—Blue Cross Executive Committee
Governor's Commission on Medical Education

November 20—Council

November 23—Council of New England State Medical Societies, Boston

November 25—Conference Committee with Connecticut State Dental Association
Program Committee, Cancer Teaching Day

November 26—Governor's Commission on Medical Education

Student Members

Peter A. Benson, Uncasville
Yale School of Medicine—Class of 1956
Pre-Med: Clark University
Parent: Hjalmar Benson

Harry H. Browne, Jr., Hartford
Albany Medical College—Class of 1956
Pre-Med: Trinity College
Parent: Harry H. Browne

STUDENT MEMBERS *(Continued)*

Felix J. M. Callan, Hartford
Yale School of Medicine—Class of 1956
Pre-Med: Trinity College
Parent: Felix J. Callan

Thomas L. Cronan, Jr., Hamden
Stritch School of Medicine—Class of 1956
Pre-Med: Duquesne University
Parent: Thomas L. Cronan

John H. Gardner, III, Hamden
Yale School of Medicine—Class of 1956
Pre-Med: Howard University
Parent: J. H. Gardner, Jr.

Herman H. Glassman, Hartford
Indiana School of Medicine—Class of 1956
Pre-Med: University of Connecticut
Parent: Max Glassman

Robert A. Goodell, Jr., Wethersfield
Harvard Medical School—Class of 1956
Pre-Med: Brown University
Parent: Robert A. Goodell

William A. Gryboski, New Britain
Yale School of Medicine—Class of 1956
Pre-Med: Harvard University
Parent: B. A. Gryboski

Sebastian R. Italia, Hartford
Yale School of Medicine—Class of 1956
Pre-Med: Trinity College
Parent: Pasquale Italia

Macey H. Katz, Hartford
Tufts Medical School—Class of 1956
Pre-Med: Trinity College
Parent: Max Katz

David J. Kiernan, Stratford
New York Medical School—Class of 1956
Pre-Med: Holy Cross
Parent: John F. Kiernan

Leonard S. Krassner, New Haven
Boston University School of Medicine—Class of 1956
Pre-Med: Yale University
Parent: William Krassner

John P. Meskunas, Waterbury
N. Y. U. School of Medicine—Class of 1956
Pre-Med: Clark University
Parent: John F. Meskunas (deceased)

Dwight F. Miller, Bridgeport
Yale School of Medicine—Class of 1956
Pre-Med: Tufts
Parent: Frank J. Miller

James P. Mooney, Shelton
New York Medical College—Class of 1956
Pre-Med: Georgetown
Parent: James P. Mooney

Paul S. Norman, West Hartford
Tufts Medical School—Class of 1956
Pre-Med: Trinity College
Parent: Sam Norman

Edward J. Ottenheimer, Jr., Windham
Yale School of Medicine—Class of 1955
Pre-Med: Harvard
Parent: Edward J. Ottenheimer

Francis G. Philbin, Milford
St. Louis University Medical School—Class of 1956
Pre-Med: Fairfield University
Parent: Leo P. Philbin

Warwick Potter, Jr., New Haven
Yale School of Medicine—Class of 1953
Pre-Med: Harvard
Parent: Warwick Potter

George E. Reardon, Hartford
Albany Medical College—Class of 1956
Pre-Med: Holy Cross
Parent: George E. Reardon (deceased)

William M. Reid, Jr., Waterbury
Cornell College of Medicine—Class of 1956
Pre-Med: N. Y. U.
Parent: William M. Reid

Vincent P. Ringrose, Jr., Plainville
University of Rochester School of Medicine—Class of 1956
Pre-Med: Trinity College
Parent: Vincent P. Ringrose

Charles M. Rohrabaugh, Jr., New Canaan
University of Pennsylvania—Class of 1956
Pre-Med: Wooster College
Parent: C. M. Rohrabaugh

Leonard P. Rome, Hartford
Tufts Medical College—Class of 1956
Pre-Med: Yale
Parent: Albert H. Rome

Francis J. Scholan, Waterbury
Tufts Medical College—Class of 1955
Pre-Med: Providence
Parent: Francis P. Scholan

Richard L. Shelling, New Haven
Boston University—Class of 1956
Pre-Med: University of Connecticut
Parent: S. A. Kelsey

Victor A. Silberman, Danbury
University of Vermont Medical School—Class of 1956
Pre-Med: University of Connecticut
Parent: Isadore Silberman

Robert A. Silver, New Haven
Tufts Medical College—Class of 1956
Pre-Med: Yale
Parent: William H. Silver

Stanley Simboni, New Haven
Yale School of Medicine—Class of 1956
Pre-Med: Yale
Parent: Milton Simboni (deceased)

Judson D. Speer, Bridgeport
Albany Medical College—Class of 1956
Pre-Med: Kenyon College
Parent: Howard L. Speer

Lewis E. Sullivan, New Canaan
New York Medical College—Class of 1956
Pre-Med: Yale
Parent: Eldon D. Sullivan

Erving A. Trunk, Danbury
University of Vermont Medical School—Class of 1956
Pre-Med: Columbia
Parent: William Trunk

Mary A. Tummillo, Hartford
Woman's Medical College—Class of 1956
Pre-Med: St. Joseph' College
Parent: Vito N. Tummillo

Romeo A. Vidone, Byram
Yale School of Medicine—Class of 1956
Pre-Med: Davis & Elkins College
Parent: Romeo M. Vidone

Edward M. Wakeman, Bethany
University of Pennsylvania School of Medicine—Class of 1956
Pre-Med: Yale
Parent: Edward T. Wakeman

Saul A. Weinberg, Hartford
University of Pennsylvania School of Medicine—Class of 1956
Pre-Med: Yale
Parent: Hyman P. Weinberg

Joseph A. Welna, Jr., New Britain
Tufts Medical College—Class of 1956
Pre-Med: Trinity
Parent: Joseph Welna

Selwyn S. Wolfson, West Hartford
University of Pennsylvania School of Medicine—Class of 1956
Pre-Med: University of Pittsburgh
Parent: Isadore M. Wolfson

Charles Zigun, Bridgeport
Yale School of Medicine—Class of 1956
Pre-Med: Yale
Parent: Morris Zigun

Of Interest to Obstetricians

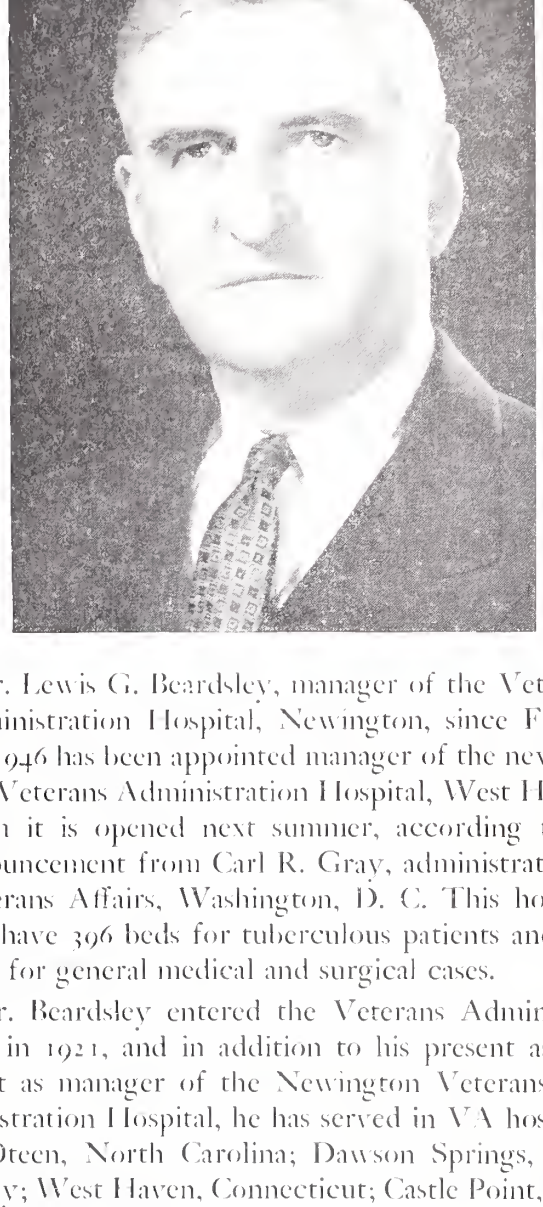
It is well known that in pregnancy the blood and plasma volume increases. At term the increase in plasma volume may amount to 40 per cent, while the increment in total blood volume may be 32 per cent or greater. This explains why losses of blood are borne so well by the parturient woman. This increase in blood plasma volume, however, may delude the clinician into believing that the parturient patient at term is anemic when in fact the apparent anemia is purely physiological due to dilution of the blood. Obviously, to add to blood volume by transfusion when a patient is in physiologic balance could well be harmful rather than beneficial.

At a recent symposium on "Indications for and Contra-Indications to Blood Transfusion," the following figures were submitted as a guide in determining the advisability of blood transfusion in women.

	RBC	H2B	HEMATOCRIT
Average non pregnant			
	4,500,000	13.0 gm. (85%)	40
Average pregnant (last trimester)			
	3,750,000	11.0 gm. (74%)	34
Anemia in pregnancy (last trimester)			
	3,250,000	10.0 gm. (66%)	30

Postpartum, the blood volume returns to normal within one week.

Dr. Beardsley to Assume New Position



Dr. Lewis G. Beardsley, manager of the Veterans Administration Hospital, Newington, since February 1946 has been appointed manager of the new 880 bed Veterans Administration Hospital, West Haven, when it is opened next summer, according to an announcement from Carl R. Gray, administrator of Veterans Affairs, Washington, D. C. This hospital will have 396 beds for tuberculous patients and 484 beds for general medical and surgical cases.

Dr. Beardsley entered the Veterans Administration in 1921, and in addition to his present assignment as manager of the Newington Veterans Administration Hospital, he has served in VA hospitals at Oteen, North Carolina; Dawson Springs, Kentucky; West Haven, Connecticut; Castle Point, New York; Washington, D. C. and in the Central Office of the VA in Washington, D. C.

Dr. Beardsley was born in Bridgewater, Connecticut. He attended Williston Academy, Trinity College and graduated from the Yale University School of Medicine in 1917. He was a lieutenant in the Medical Reserve Corps of the Army in World War I and served as a colonel in the Army Medical Corps in World War II.

Concurrent with the announcement of this appointment, Mr. Gray announced the appointment of Alan W. Chadwick as assistant manager at the new VA Hospital in West Haven. Mr. Chadwick is at present assistant manager at the Newington Veterans Hospital.

A native of Worcester, Massachusetts, Mr. Chadwick graduated from the University of Massachusetts in 1931. He served as a captain in the Medical Administrative Corps in World War II. Prior to his army duty he was Superintendent of the Hospital Cottages for Children, Baldwinville, Massachusetts. He is a member of the American College of Hospital Administrators.

Dr. Beardsley is a member of the Connecticut Trudeau Society, the Hartford County Medical Association, and the Connecticut State Medical Society. He is a clinical professor of medicine at the Yale University School of Medicine. Both men are members of the Connecticut Hospital Association and the American Hospital Association. The date of transfer to the West Haven hospital will be announced in the near future.

Successors to Dr. Beardsley and Mr. Chadwick, manager and assistant manager, respectively, of the VA hospital at Newington, Connecticut, will be appointed before the new hospital at West Haven is completed.

Medical PTA Hospital Day

Hartford's first medical PTA hospital education day, with more than 125 parents and teachers taking part, was held Monday, October 27 at Mt. Sinai, St. Francis and Hartford hospitals.

The event sponsored by the Hartford County Medical Association, the three participating hospitals, and the PTA, featured hospital tours and a coffee and question period.

John O'L. Nolan, public relations chairman of the HCMA, said the program was designed to show the members of the PTA what was necessary in making a patient well from the medical and hospital viewpoints.

At Hartford Hospital, John C. Leonard spoke about a doctor's training, his role in providing skilled medical care and his responsibility to the patient. Dr. Nolan at St. Francis Hospital and Dr. Isadore S. Geetter at Mt. Sinai Hospital presented similar talks.

Our Student Membership

The success of our student membership from the start has been one of great encouragement to an enterprise which seeks to extend the Society's interest in tomorrow's doctors. The following letter to our executive secretary shows how much our effort is appreciated.

"Harvard Medical School,
"October 23, 1952

"Dear Sir:

"Enclosed find my application for special student membership in the Connecticut State Medical Society. Also enclosed is a check for two dollars and fifty cents for a student subscription to the State Medical Journal.

"I want to express my appreciation to the Society for presenting such a valuable opportunity and I hope that this is just the beginning of a long and fruitful association.

"Being at a school which has national distribution, the attention shown by your Society in recognizing Connecticut students makes me proud that Connecticut is my home state.

"Thank you again for the opportunity offered. I only hope I am able to maximize its tangible and intangible benefits.

"Sincerely,
"Joel J. Alpert"

Connecticut Nurses Receive Top Pay

Among the northeastern states, the private duty nurses of Connecticut along with those in New Jersey, parts of New York and Pennsylvania receive the highest pay. Following are the rates quoted from *Nursing News*.

Pennsylvania—Recommended minimum rate: $10 for 8 hour duty. Three urban areas receive $12.

New York—$12 for 8 hour duty. Eleven districts receive $12; two districts receive $11, and four districts receive $10.

There are 4,273 private duty nurse members in the NYSNA.

New Jersey—$12 for 8 hour duty. Statewide acceptance.

Rhode Island—$10 for 8 hour duty. Statewide acceptance.

Massachusetts—$11 for 8 hour duty.

New Hampshire—$10 for 8 hour duty. Statewide acceptance.

Vermont—$10 for 8 hour duty. Some areas receive $8.

There are 90 private duty nurse members in the VSNA.

Connecticut—$12 for 8 hour duty. Statewide acceptance.

There are 597 private duty nurse members in the CSNA.

The Maine SNA did not reply to Miss Roper's questionnaire.

Dr. Donaldson Retires

Dr. Walter F. Donaldson of Pennsylvania, who has held several offices in the American Medical Association, was guest of honor recently at a Pennsylvania State Medical Society dinner which marked his retirement as secretary-treasurer of the state society. He served the state society as president in 1917, and as secretary from 1917 to 1944, when he was elected secretary-treasurer. He has been re-elected to that office annually since that time.

Dr. Donaldson, who has endeared himself to the hearts of physicians not only in Pennsylvania but throughout the nation, was a member of the AMA House of Delegates from 1923 to 1947. Since 1931 he has been a member of the Judicial Council, after serving on the Council on Medical Education and Hospitals.

The JOURNAL bespeaks for this medical veteran many happy years as a useful citizen.

From the Secretary of AMA, Dr. Lull

I'm back at my regular chores in headquarters after attending the meeting of the Council of the World Medical Association in Athens.

While abroad, I talked with physicians from many countries. The stories some of them told me made my heart ache. As I left for home, I couldn't help feeling proud of our American system of medical care. In many of the countries I visited, the long arm of socialism has reached into the profession to such an extent that the only thing the doctors can do is to bargain and make the best deal possible with their governments so as to save the remnants of what was once a free profession.

THE HISTORIAN'S NOTE BOOK

DR. MASON FITCH COGSWELL

ARTHUR S. BRACKETT, M.D., *Bristol*

How many of us know, when we go to a meeting in the Hunt Memorial at 8 Prospect Street in Hartford, that Dr. Mason Fitch Cogswell used to live on this very spot when Hartford in 1830 had 9,789 inhabitants? And that he was then probably the best surgeon in America? But it is not as such that I like to think of him; rather, as a young man coming on horseback from Stamford to Windham to spend Thanksgiving in 1788 with his father and to look over the ground for a place to settle down to make a living as a physician and surgeon.

His father was the Rev. James Cogswell who had been pastor in Canterbury, Connecticut from 1744 to 1771 and subsequently for six years in the parish of Scotland. His mother, Alice Fitch, was a descendant of Captain Mason who had led the Connecticut troops in the Pequot War, and she was also a descendant of the Rev. Mr. Fitch of Norwich.

At Norwich, Mason Fitch Cogswell had prepared for entrance into Yale. Although the youngest of the class of 1780, he was valedictorian. After graduation he had trained with an elder brother who was a surgeon in the War of the Revolution. Later, Cogswell was in Stamford where he was a choirmaster and probably played the flute with the choir. All of his life he loved music.

But none of these things interest me as much as a diary that he kept while traveling on horseback from Stamford to Scotland. At present this diary is in the Yale Library, almost worn out with age and wandering. Almost a century later the Rev. Dr. Leonard Bacon of New Haven made copious annotations concerning this diary. The first page is missing, but on the third Mason wrote that he had slept "luxuriously" after "dining on sweetmeats, cream pompion pie and bridal kisses."

The journey was made on horseback, stage coaches did not run regularly.

November 14, 1788 he got up early, made several calls, had his horse shod and set out for Norwalk, where he made a cousinly visit and slept "for nothing." In the evening called on Miss C—n, who greeted him "with smiles and sprightly wine."

November 15 rode to Greenfield and breakfasted with the Rev. Mr. Dwight, where he stayed longer than he had expected. Dined in Stratford, where the friends he had hoped to see were not at home. Then he pushed on to New Haven, arriving there after sunset. He found that his old friend Leander was out of town. "Repaired to Mr. H's," where he was invited to spend the night. Dr. Bacon thinks that H— was Captain James Hillhouse.

The next day, Sunday, attended divine service at the Brick (Church) and went in the afternoon to his "old place of worship. The discourse was accompanied with good music." In the evening he visited Dr. Stiles where the ladies were the "same as when I was at New Haven." He had graduated eight years before.

November 17. Visited old friends feeling "happy myself and endeavoring to make others so." In the evening joined a party of about 20 couples and danced till midnight and thoroughly enjoyed himself. In those days, dancing meant square dancing, minuets, etc.

November 18 breakfasted with Samuel Broome, who probably had been at the party of the night before. He and Broome started for Hartford by way of Cedar Hill and North Haven and then to Wallingford. At that time the Middletown turnpike had not been built.

Spent the night at Wallingford. Next day, the 19th, they breakfasted at Durham, dined at Middletown and arrived in Hartford about sunset. "As soon as our horses were attended to we repaired to Col. Wadsworth," who lived at the site of the present Wadsworth Athenaeum. There they were invited to spend the evening. "The beautiful Miss H—(Hopkins), the handsome Miss S—(Seymour), and the pretty Miss B— were of our party. Music, dancing and sociality constituted our amusements." They left when the curfew rang at nine o'clock.

Thursday, November 20, after breakfast at his lodgings he "sat for half an hour under the hands of the frisieur" where his hair was powdered and his queue tied with a black riband. Then he went to Dr. Strong's, who was pastor of the Center Church. He was grieved to find Mrs. Strong very sick. He had been invited to dine at Colonel Wadsworth's, who lived next door. Those at the table that day were "Mr. & Mrs. Wadsworth, Miss St. John, Misses Harriet and Caty, Messrs. D. Wadsworth, Samuel Broome and myself." After dinner the "ladies retired to dress for a visit to Miss Bull, except Miss St. John who had a toothache." While waiting for the ladies they amused themselves in the parlor with music. After tea they returned to Col. Wadsworth's and stayed till ten o'clock, discussing various subjects.

Friday, November 21. After breakfast he went to the Talcott mansion on the Hill, later the site of the American Asylum for the Deaf and Dumb, now occupied by the Hartford Fire Insurance Company. The Talcotts were a well known family at that time.

Saturday, November 22 he was ferried across the Connecticut river and arrived at his father's in Scotland in the evening.

Sunday, November 23 he attended Divine service and was delighted both with the preaching and the music.

Monday was cold and stormy. Tuesday he visited old friends. Wednesday again was stormy and cold. He spent the day with his father who was indisposed. In the evening "I went up to Esquire Devotion and drank a mug of flip with him and ate pompion pie with his wife."

Thursday, his father being sick, he asked Mason to conduct the service. The music was fine and the service was concluded with the anthem from Isaiah, "Sing, O ye heavens, etc." After service he went to Squire Devotion's, where they ate turkeys, pigs, pompion pies, apple pies, tarts, etc. (Why is mince pie never mentioned?) After supper he went home to his father's, gave thanks, smoked a pipe, went into the kitchen, sang with his sisters Polly and Betsy and ate apples and nuts before going to bed.

Friday he rode to Windham, dined at Major Backus's, where "pompion pies are again in abundance," then rode to Lebanon, where he found a friend at Mr. Porter's with his sister Eliza and Emily and Sophy Porter. This Mr. Porter had been confidential secretary to Governor Trumbull of Revolutionary War fame. So it was not surprising that Miss Trumbull should come in "for an hour or two." They all had a delightful time.

Saturday, November 29 was wet, so they "waded over to Col. Trumbull's" for an hour with him and Mrs. and Miss Faithy Trumbull.

Sunday, November 30 arrived at Gov. Huntington's in Norwich at 8:30, where he was warmly welcomed. His morning's ten mile ride was not enough to keep him from both morning and afternoon services. (In all the diary no mention was made of cold churches, which in those days were unheated, except with foot stoves.) In the evening he called at Mr. Woodbridge's, where Clara and Hannah were as glad to see him as he was to see them. He stayed four days longer in Norwich (where he had been prepared for Yale), visiting old friends. "Refused several invitations to dine out, so that I might eat turkey with the Governor. Thanksgiving not gone yet, for we had flip and pompion pies both. Drank several glasses of port" and discussed the politics of the day.

On Tuesday "breakfasted with Gen. Huntington, dined at Dr. Lathrop's, drank tea at Mr. Andrew Huntington's and supped with William Leffingwell." He returned to lodge at the Governor's.

The next day he dined at William Leffingwell's, a classmate at New Haven. "His sister Joa. is a smart girl. Sam'l Huntington and Dan Lathrop were also of our party; a full grown turkey and pompion pie, etc., everything in nice order."

Thursday breakfasted with his "old friend Shubael," dinner with the Governor and family, and at Mr. Breed's with more pompion pie. An after dinner call at Mr. Coit's. Tea at Mr. Moore's and the evening at Mr. Leffingwell's again in a circle of no less than 16 ladies.

On Friday, December 5, he called on uncles and aunts in Lisbon, Preston and Canterbury. On Saturday arrived at his father's house in Scotland, where he was detained by stormy weather.

The next Wednesday went to Mansfield to see more cousins. Coming back to Lebanon again he had another "charming evening with the ladies." The next morning, Friday, December 12, he walked over to Col. Trumbull's to get letters to carry to Hartford, for the postal service was as yet not dependable.

On returning to Hartford he had a talk with Dr.



Americaine

TOPICAL ANESTHETIC OINTMENT

WITH 20% DISSOLVED BENZOCAINE FOR RAPID EFFECTIVE, PROLONGED PAIN RELIEF

Most Potent — Least Toxic — Antiseptic — Facilitates Healing — INDICATIONS: Eczemas, Hemorrhoids, Burns, Insect Bites, Sunburn, Pruritus Ani et Vulvae, Post-Operatively, Post-Episiotomies, Tender Nipples, Abrasions, Poison Ivy, etc.

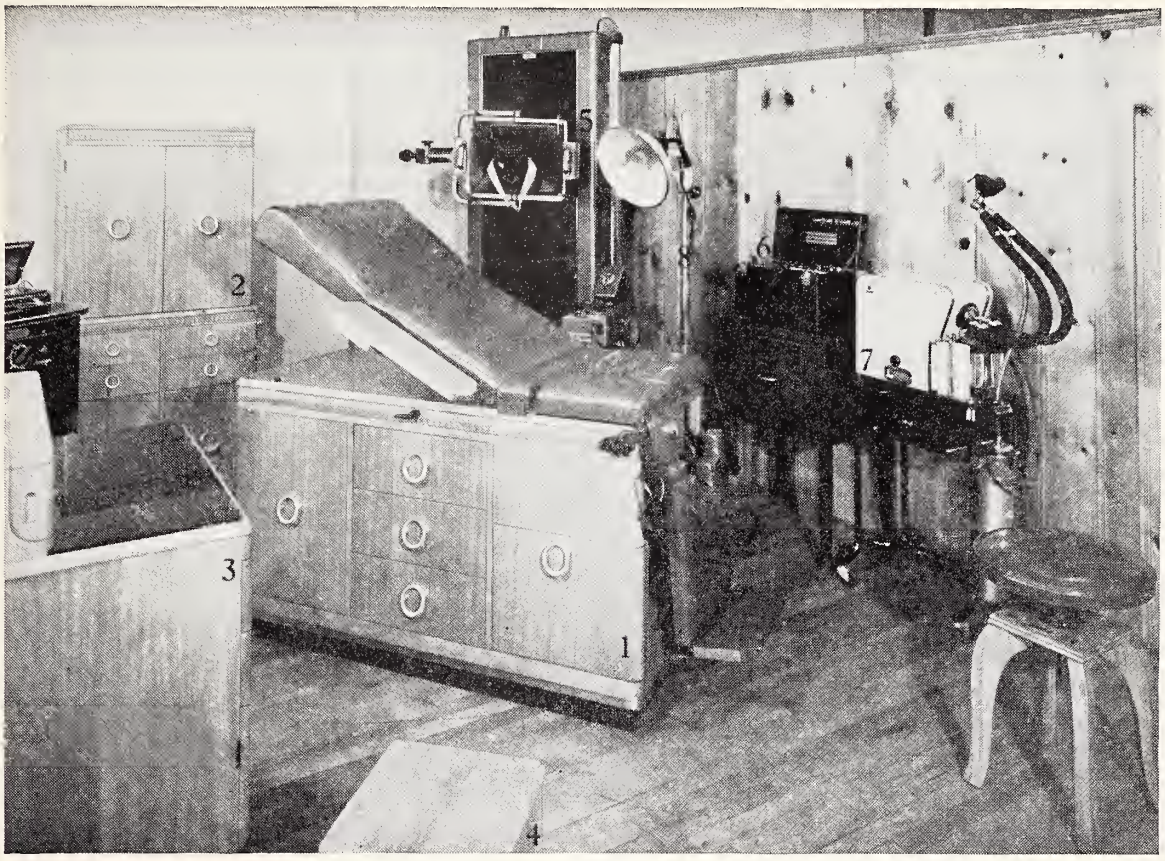
Available "Clear" and "With Chlorophyll"

☆ *Now available in Liquid form in Aerosol Spray Dispensers . . . . .*

☆ *Just Press Button and Spray On . . Relief in Minutes - Lasts for Hours*

Now relieve surface pain and itching in minutes — provide relief for hours — with new Americaine Aerosol. *(Same as Americaine Ointment, except new liquid vehicle.*)* Patients scarcely feel Americaine Aerosol being applied, yet it goes to work at once and is safe to use. Because it is bacteriostatic, it also helps guard against infection.

Americaine Aerosol has special value in your First Aid treatment rooms and field kits.



One section of our large display room in Bridgeport

Telephone 5-3116 -- Enterprise 3190

American Surgical

SUPPLY and EQUIPMENT CO.

1715 BARNUM AVENUE P. O. BOX 150

BRIDGEPORT, CONNECTICUT

Offering — nationally famous makes of FURNITURE, EQUIPMENT and supplies including

W. D. Allison Company
Shampaine Company
Ritter Company
Welch-Allyn Company
Johnson & Johnson
Armour Laboratories
Schenley Laboratories
Bristol Laboratories
Raytheon Manufacturing Co.
Birtcher Corporation
Ethicon Suture Laboratories
Davis & Geck
J. Sklar Manufacturing Co.
Davol Rubber Company
Seamless Rubber Company
Becton, Dickinson & Company
Arnar-Stone Laboratories (Americaine)
North American Philips Co.

and many others

Lemuel Hopkins, probably about settling in Hartford. After this the diary becomes undecipherable—the last words "they are lovely girls and on the high road to make husbands happy."

It is very evident that after seeing so many happy couples he was impatient to settle down and have a home of his own. We know that he did settle down in Hartford, where he became a famous surgeon and married Mary Ledyard. Their youngest daughter, Alice, had the "spotted fever"—now called cerebrospinal meningitis—when two years old and became totally deaf. He became instrumental in founding the American Institute for the Deaf and Dumb.

For the account of his life while in Hartford the reader is referred to Dr. E. R. Lampson's monograph in the *Yale Journal of Biology and Medicine*, October, 1930.

One should read "Extracts from the Diary of Dr. Mason Fitch Cogswell compiled by Ellen Strong Bartlett from annotations of the Rev. Dr. Leonard Bacon, in the *Connecticut Quarterly*, Vol. V.

Dr. Bacon was a Congregational clergyman, who was born in New Haven in 1830 and lived until 1907. He must have made his annotations before 1899. He mentions knowing the "girls" of the diary as old ladies. His observations add much to the value of the diary as a picture of the manners of the time.

References given by Dr. Lampson are: MSS Yale Library; MSS Connecticut Historical Society; Medical Repository, Vol. II, p. 99; Williams Medical Biography; Physicians in Hartford 1820 and 1837; George Summer and Gurdon Russell—Memorial History of Hartford County; Yale Biographies and Annals (Dexter); New England Journal of Medicine & Surgery, Vol. 13, p. 356.

Some of his ledgers may be found in the Connecticut Historical Society's building, 1 Elizabeth Street, Hartford, Connecticut.

Record Year For Connecticut's Hospitals

The number of patients in Connecticut's 33 general hospitals soared to a new high during the past year, while their average length of stay continued its downward trend.

This is indicated in a report issued by the Connecticut Hospital Association for the hospital fiscal year ended September 30.

The number of patients, the report states, increased to 243,907, an all time record for the general hospitals of the State and an increase of 13,056 patients, or 5.7 per cent above the prior period. The average length of stay declined 2.8 per cent, from 8.1 to 7.9 days.

Even babies did not stay as long in the hospitals as had those of the previous year. While the report does not include the newborn, an accompanying tabulation indicates their average length of stay declined 2.5 per cent, from 6.3 to 6.2 days. There were more births, too—they increased 8.3 per cent, from 40,360 to 43,708.

The number of maternity patients increased at a higher rate than medical and surgical patients, 8.1 as against 5.1 per cent. Maternities represented 20 per cent of the patient load and numbered 48,850 compared to 45,197 for the 1951 fiscal year. The year saw surgical and medical cases rise from a previous 185,654 to 195,057. Maternity cases also led in average length of stay reduction. They decreased 3.7 per cent (5.6 to 5.4 days) while the medical and surgical average dropped 2.5 per cent (8.8 to 8.6 days).

Commenting on the use of hospital facilities, Hiram Sibley, the Association's executive director, states "the trend was markedly towards greater utilization of semi-private accommodations and a corresponding decrease in staff ward beds occupied."

Only staff ward patients showed a longer average period of hospital stay. Their average climbed from 11.2 days to 11.4 days, a 1.9 per cent increase. But the total number of these patients dropped 9.9 per cent, from 35,526 to 32,011.

The largest percentage increase of patients occurred in the semi-private and private ward group, 8.5 per cent—from 168,466 to 182,866. This was closely followed by the private patient group, which showed an 8.1 per cent increase in numbers, 26,859 to 29,030.

The total hospital days for all patients, excluding the newborn, are recorded at an impressive total of 1,930,999, a 2.7 per cent increase above the 1,880,673 days spent by patients in the 33 hospitals the year before.

Consolidated Fund Raising

From the Annual Report Campaign Policy Committee, American Cancer Society, Connecticut Division

The past five years have seen the development in this country of a movement to consolidate all fund raising appeals under a single banner. This movement is not new, for the first steps in this direction were taken following World War I, based upon the successful consolidation of appeals under a United War Fund. At that time the largest health or welfare agency making a national appeal for funds was the American Red Cross. The many great voluntary health agencies which we now recognize had not come into existence or were not conducting organized national campaigns. This first attempt resulted in a failure and withdrawal of the American Red Cross from all such local organizations. It did result, however, in the organization of community chests on a national basis. These chests continued to serve predominantly local agencies, although in the years leading up to the second World War, some national agencies were included in certain localities.

The United Defense Fund during the second World War, which added to this structure principally the United Service organizations' appeal, served as a focus for renewal of interest in united or federated fund appeals in many areas of the country after the war. Large organizations of this character in many of our leading cities, such as Detroit, Philadelphia and Los Angeles made their appearance and recently we have seen moves toward the establishment of united fund appeals on a state wide basis. The better established national health agencies, such as the American Cancer Society and American Heart Association, have resisted inclusion of their local units in these appeals. In many places, however, the pressure exerted upon the volunteers manning these local organizations from business associates, organized labor, community chests, chambers of commerce, and citizens organizations, has been severe and unremitting. The result was that many local units capitulated to the pressure, and it became necessary for the American Cancer Society to make provision for certain of its local units, which were threatened by dissolution of their entire programs, to join in united funds under certain special conditions. Almost two hundred local units scattered throughout the country have taken advantage of the opportunity so afforded up to the present time. Their experiences in doing so have not been entirely happy, and the American Cancer Society has emphasized repeatedly that the decision to allow such participation must remain primarily with each division, and that it in no way encourages this trend.

The Connecticut Division was one of the first to recognize the danger not only to its fund raising campaigns, but also to its entire program, dependent as it is upon the support of its thousands of volunteers for the education and service phases of its activities. This Division has maintained a firm stand against inclusion in any federated fund from the outset and has received commendation from the American Cancer Society for its success in maintaining the independent nature of its appeal.

The year of 1952 saw no change in the policy of the American Cancer Society, Connecticut Division, with regard to participation in united or federated funds. This statement alone could serve as a complete report for this Committee. Its simple and affirmative character has characterized the attitude of officers and volunteer workers of this Division almost without exception. Although this attitude has been characterized by some outside the organization, who wish to see a change in policy, in unflattering terms, the nicest thing that has been said about it is that it is uncompromising. We have felt that in this battle to save lives and prevent needless suffering that any compromise of methods, which have demonstrated and continue to prove their effectiveness, would be a betrayal of the great responsibility bestowed upon us by our millions of loyal supporters.

That simple statement, however, would not do justice to the story behind the firm maintenance of this policy. The vigor and virulence of the attacks against one of our local branches for maintaining its independent campaign in the face of overwhelming pressure, asserted socially as well as through the press, on behalf of a united fund campaign can scarcely be imagined when it is recollected that the basis of the disagreement was the method of collection of voluntary gifts to relieve human misfortune. Most unfortunate of all was the fact that this attack was supported by some who had previously served as devoted volunteers of this organization and who had become honestly confused by the illusory promises of federation proponents. This attack was withstood by the vigorous efforts of loyal volunteers working in conjunction with personnel of the State office and this Committee. A successful independent

campaign was carried out by this branch and the outlook for the future now appears bright.

This Committee has pointed out again and again that it in no way wishes to criticize the idea of community chest or other joint campaigns where the associated agencies participate voluntarily as a matter of policy. Many of our volunteers are, in fact, leading workers in such campaigns, which serve local agencies. We have emphasized, according to our observations over a long period of time, that the combination of appeals organized on a national basis with those for purely local agencies does not appear to work out to the advantage of all concerned and that in the long run such combinations have a poor record of success and survival. With the increasing number of appeals now being made nationally for causes associated with health alone, and with many of these appeals virtually untested as far as their independent fund raising ability is concerned, it will be virtually impossible for any united fund to include them all and to set up budgets and allocations on an equitable basis.

Whereas many of these newer organizations have chosen to participate in united fund appeals because they have not established any district or local organizations, or because their appeal is not broad enough to enlist the required number of workers, officials of such united funds have been able to promulgate the idea that such participation by all national health agencies is desirable. We wish to re-emphasize the fact that our reasons for maintaining an independent campaign preclude the possibility of our participation in such united funds, even were every other similar voluntary health organization to participate. Further than that, the participation of some voluntary health organizations, together with the desire of united fund directors to provide a comprehensive and attractive package for the giver, has led to a practice in the budgeting programs of these federations, which threatens us with the possible disintegration of well organized voluntary health movements.

I refer to the practice of allocating in advance certain sums of money solely under the names of disease conditions, such as "cancer," "heart," "poliomyelitis," etc., without regard to any specific program or organization. Contributions to the American Cancer Society are utilized effectively because they support a program which has been designed and tested by experience to include all of the important phases of the attack against cancer. The program is balanced by consideration of the particular needs of the moment as well as a long range plan and is regulated in such a way that it can be immediately sensitive to the latest promising developments in the field of cancer control. The faith, which the American people have in this program, is demonstrated by the increasing amounts of money contributed to our annual campaigns. During this year's campaign in Connecticut our citizens contributed $400,000, the largest sum ever raised. In spite of disastrous flood conditions affecting a good portion of our Middle West at a time immediately preceding our campaign, the total amount contributed to the American Cancer Society this year was well over $16,000,000—again a new record in contributions. What purely local fund raising organization can develop on its own a comprehensive program for the control of any disease state without necessarily setting up in miniature a rival voluntary health organization? What a damaging effect on a confidence of the public in voluntary health organizations occurs when this hook, which has been baited to lure the unwary organization, is refused and the public realizes that it has been duped!

In conclusion, we have recommended to the Executive Committee that the Society's plan of dealing with problems arising from federated fund raising appears to be correct and has already met with considerable success, although there is still something to be accomplished. We recommend the continuation of a Committee of this kind to help the Society hold a firm line against future involvement in federated fund raising schemes. New inquiries from communities considering programs of this kind are still reaching us. Although the peak of enthusiasm for this type of united activity may have been reached, the subject is still a very lively one.

Push Petition On Canadian Health Scheme

The Canadian Press from Winnipeg reported that the Cooperative Commonwealth Federation soon will ask Canadians to sign a petition urging the federal government to launch a national health insurance program.

The decision to circulate the petition was announced by M. J. Coldwell, CCF leader, in a speech over the Trans-Canada network of the Canadian Broadcasting System.

National health insurance, he said, has been in the Liberal Party's platform since 1919 and there have been "33 years of procrastination and delays."

MILITARY AFFAIRS

COMMITTEE ON MILITARY AFFAIRS

Cole B. Gibson, Meriden Stanley B. Weld, Hartford Harold Speight, Middletown

Doctor-Draft Law

Department of Defense is getting ready to fight for extension of doctor-draft law, which is due to expire in July. Experience has convinced Pentagon that there is no other way to assure military's getting the physicians and dentists it must have. And it may take a real fight on Capitol Hill, beginning in January when Congress comes back, to gain an extension. Dissatisfaction is mounting over administration of the law by Selective Service—slow processing of registrants, policy inconsistencies on deferments for essentiality, friction with armed services themselves and an increasing tendency on part of SS headquarters to withhold information that is requested on its procedures. Although the professional societies may reluctantly "go along" with extension of Public Law 779, if no workable alternative can be presented, they are likely to raise their voices loud and strong for a more efficient administration of the statute, as well as elimination of its kinks. General Hershey's office is loath to answer questions pertinent to current callups of physicians and dentists, even though its supplying of information might well facilitate the task of filling monthly quotas.

Defense Department's Armed Forces Medical Policy Council sponsored the first discussion meeting, attended by spokesmen for dentists, veterinarians, hospitals, and medical schools, as well as the American Medical Association. Represented also were the Armed Forces, Defense Department's manpower division, Selective Service and the Rusk committee.

At the first meeting, held in the Pentagon, a Defense Department spokesman gave this outline of the problem:

1. Medical Priorities I and II will be exhausted shortly, and future requirements will have to be met from Priorities III and IV. Questionnaires are now being sent to a number of physicians in Priority III.

2. There aren't enough young men in Priority III to meet military requirements for long; unless the younger men in Priority IV are made available by a change in the law, the services will be offered too many of colonel and major age and experience, not enough for the captain and lieutenant commissions. Dislocating physicians of 15 to 20 years' experience from their civilian practice will create additional problems.

3. The age and experience level of Priority IV men make many of them more acceptable, but it is possible that a high percentage already have had two or more years of active military duty; besides, these men can't be called until Priority III has been used up.

4. The professional manpower shortage will continue until 1958, when enough non veterans, currently deferred from the regular draft to complete their medical training, will be available to meet most military requirements.

No conclusions were reached at the first meeting, and association representatives were not asked to pledge support for an extension of PL779 at this time.

Medical Picture Brighter

Whereas there is mounting uneasiness among dentists under 51 with well established practices, civilian security for their medical counterparts in Priority III seems assured for months to come. Official Selective Service figures show a pool of 2,029 Priority I's in Reserve Medical Corps who are yet to be activated and 451 more in II. In addition, there are—or were as of September 30—857 I's and 567 II's who were in 1-A and physically fit, also 591 1-A's in Priority I and 216 in II who had not yet been examined. Classification of Priority III physicians is continuing at a rapid pace but even considering that armed forces are discharging hundreds of Reserve medical officers each month, the Priority I and II pools are deemed ample to supply replacements for at least next six months.

Army MSC Helicopter Evacuation Service "Officially Integrated"

Helicopters equipped as ambulances, which have been evacuating combat casualties since the early days of fighting in Korea, now are being recognized officially as an integral part of the Army Medical Service organization.

The Army announces that 34 man helicopter units will be assembled and trained as distinct organizations. Each unit will include five two-rotor utility helicopters capable of carrying three litter patients or four ambulatory patients, as well as a medical attendant and pilot.

Pilots will be Medical Service Corps lieutenants specially trained in basic aviation and helicopter operations at the Army's aviation flight training center, Fort Sill, Oklahoma, where the first training course is now being conducted. Other personnel for each unit will include a MSC captain as commanding officer, an operations officer and 21 enlisted technicians.

The first unit is being activated at the MSC school at Fort Sam Houston, Texas, where it will be used for training purposes. Other units will be formed as soon as personnel, equipment and training facilities become available.

Members Who Have Entered Military Service

Frank H. Horton, Lt. (jg) (formerly of Manchester), Great Lakes Naval Hospital.

Kenneth W. Schenck (Comdr USNR) (formerly of Storrs), 3534 N.E. Sandy Boulevard, Portland, Oregon.

Dinner Meeting of Gastroenterological Section

The Gastroenterological Section of the State Society held a dinner meeting at the South Meriden House on Wednesday, October 15. At this meeting the by-laws of the Section were amended so that diplomates of specialty boards recognized by the American Medical Association in fields related to gastroenterology are now eligible for senior membership. Associate membership is open to all members of the profession who have a scientific interest in gastroenterology. The scientific portion of the program was given over to a discussion of "The Postcholecystectomy Syndrome." Max Caplan, Meriden, discussed the incidence of symptoms following cholecystectomy and their most frequent causes. Robert Shapiro, New Haven, reviewed many of the pitfalls in cholecystography. Milton M. Lieberthal and Joseph J. Esposito, both of Bridgeport, pleaded for more widespread use of cholangiography, particularly at the operating table. Max Taffel, New Haven, reviewed the pathologic processes most commonly found responsible for postcholecystectomy syndromes including (a) residual cystic duct stones, (b) residual common duct stones, (c) stenosis of the ampulla, (d) syndromes caused by a cystic duct remnant, (e) allergy, (f) biliary diskinesia and (g) neuroma in an amputated cystic duct. There was further discussion of surgical aspects of sphincterotomy, particularly with reference to the length of time a long arm T tube should be left in place, if indeed it should be used at all. Dr. Taffel did not favor using a long arm T tube but Courtney Bishop, New Haven, believed that one should be employed. There was considerable disagreement as to the hazard and the value of cholangiography at the operating table. Although anesthesiologists oppose this procedure because of the danger of explosions it was felt that this hazard was minimal if cyclopropane were not used. Alfred Hurwitz, Newington, pointed out that cholangiography on the operating table was often misleading particularly because air bubbles might be interpreted as stones. Dr. Shapiro and Dr. Esposito both rejoined that radiologists were more confident now than they had been in the past about their interpretations of cholangiograms. They pointed out that if sufficient films were made, bubbles generally tended to move. All the surgeons present agreed that the sound amplified technique for detecting stones in the common duct had proved a disappointment.

The next meeting of the Section is to be held at the South Meriden House on the fourth Wednesday in January, 1953. Members of the State Society who have a major interest in gastroenterology and would like to join the Gastroenterological Section are invited to communicate with the secretary, Benjamin V. White, M.D., 85 Jefferson Street, Hartford.

NEWS FROM WASHINGTON

President's Commission on Health Needs of the Nation

The President's Commission on the Health Needs of the Nation is now embarking on its biggest task: that of drafting and compiling its final report and recommendations which, Chairman Paul B. Magnuson says, will be ready between December 1 and 15.

The Commission set to work on the report after hearing two days of testimony, in Washington, on the controversial problem of financing medical care. It listened to evidence presented by 21 professional and lay representatives. A comprehensive summary of testimony presented at this meeting appeared in the Washington News section of the *AMA Journal*, October 18, and also in the October 14 issue of *Capitol Clinic*.

The first report to be given out by the Commission will be a 100-page summary of "the state of the nation's health."

This summary will be quickly followed by publication of the following documents: about 500 pages covering this nation's health status, needs and resources; a statistical appendix on health status, giving tables and charts; a statistical appendix on the financing of health services, personnel, education and research, and excerpts from regional public hearings.

Most of the writing of the report will be done by the Commission's staff in Washington. The editing and whatever rewriting is necessary will be done by H. B. van Wesep, who has been head of the Office of Publications of the Rockefeller Foundation in New York for 25 years. He will go over the material as it is turned out by the Commission's staff and put it in final shape for the printer.

In a two day symposium held in Washington in October the two representatives of the AMA urged realistic appraisal of what the American public spends for medical care and what it gets in return. The growth of Blue Cross and Blue Shield was traced and future development forecasted. No objection was raised to the principle of health insurance nor was there any resistance from any quarter that the traditional fee-for-service system must be retained as a cornerstone.

Michael M. Davis, chairman of the Committee for the Nation's Health, said that State medicine will be the fearsome consequence of our failure to adopt government insurance. Harold M. Groves, economist from the University of Wisconsin, proposed a plan of compulsory tax on incomes that would go into a national fund for defraying expenses incident to catastrophic illness. Harry Becker, associate director of Commission on Financing of Hospital Care, proposed federal subsidies to medically indigent enabling them to pay Blue Cross and Blue Shield premiums, rather than financial support of plans themselves.

The dean of University Colorado School of Medicine stated that financial support of medical schools is inadequate.

Efficacy of Rutin Denied by FTC in Unusual Verdict

Federal Trade Commission last week took an extraordinary step. Issuing a desist order in a case which, of itself, is of minor importance, FTC virtually branded as worthless a drug frequently prescribed by physicians in hypertension, diabetes and retinitis cases. The drug is rutin, manufactured by ten or more reputable pharmaceutical houses and which has been under respectable clinical use for last five years or longer. Target of FTC's order curbing advertising claims was a preparation marketed as "Celparux," each tablet containing 20 mg. rutin and larger parts of parsley, celery and ascorbic acid. But the Commission went further, holding that rutin itself presents no evidence of therapeutic value, notwithstanding its continued use by the profession.

". . . that a substantial number of physicians are prescribing it as a treatment for the very 'conditions' advertised by respondents is . . . immaterial," said the decision. "That a segment of the medical profession may be misleading diabetics is no excuse for respondents likewise doing so."

EXPERT TESTIMONY PRESENTED

Vigor of FTC's rejection of rutin is traced to testimony which was taken from four internists—two Clevelanders, a New Yorker and a Philadelph-

ian—and a Cleveland ophthalmologist. The internists all reported negative results in treatment of diabetics with rutin, with reference to relief of retinopathy, capillary fragility, hypertension or retinitis. The ophthalmologist reported equally discouraging results, over a two year period, in treatment of retinopathy in diabetic and hypertensive patients. Their collective opinion was that rutin will neither retard, relieve or cure retinitis or retinopathy in diabetics or hypertensives, nor is it effective against capillary fragility. Although their conclusions were challenged as too sweeping by a Philadelphia physician testifying in behalf of Hatoco Co. of New Orleans, makers of "Celparux," he conceded that it is still moot whether diabetics receive any benefit from rutin dosage.

Vocational Counseling Now a Medical Function in VA

Managers of all Veterans Administration hospitals have received instructions relative to establishment of vocational counseling services under medical supervision. Formerly this phase of hospital care was in lay hands of VA's Vocational Rehabilitation and Education branch. Program will be developed gradually, rate of growth depending chiefly on availability of funds and of trained, qualified personnel. "It is the intention," says directive sent to VA hospitals and medical centers, "that vocational counseling service will be available to all patients who need it, without reference to the question of service connection or nature of the disability."

Health Items 35 Per Cent of UN Children's Fund Budget

The 26 nation executive board of United Nations International Children's Emergency Fund has approved programs for the next year or more, totalling about $7,154,000. Approximately 35 per cent is directly related to health: maternal and child welfare, $1,962,000; health training programs in maternal and child welfare, $34,000; mass health programs, including combating insect borne diseases and yaws, BCG vaccinations and other tuberculosis control measures, $508,000. Since the establishment of UNICEF by the UN General Assembly in December 1946, the equivalent of more than $166 million has been received by the agency from 58 governments, left over assets of UNRRA and from national campaigns of the United Nations Appeal for Children. With the payment of $6,666,667 appropriated by the last Congress, the U. S. contribution to UNICEF will amount to around $87,750,000 or more than half the total from all sources for the six years.

Senate Government Operations Committee Planning January Hearing on VA

Chairman John L. McClellan of the Senate Government Operations Committee, plans to call a hearing in mid-January on the management survey report of the Veterans Administration which is still to be made public. The $605,000 top-to-bottom investigation on VA operations, including medical activities, was completed last spring and recommendations by the firm of Booz, Allen & Hamilton have been studied by various VA officials. These officials have made their recommendations on the report to VA Administrator Carl Gray and release is now up to President Truman and General Gray.

Chairman McClellan has been trying since June to get a copy of the report so that the committee staff could study it and make recommendations for remedial legislation before the new Congress convenes early in January. Senator McClellan was unable to get a copy but it was decided to proceed with the January hearings regardless.

The committee staff, upon adjournment of Congress last July, initiated studies into operations of the VA, with special emphasis on hospital construction, utilization of hospital facilities and medical personnel and on the possibilities of improving the administration of the veteran's insurance program. These studies have been held up until they can be compared with the management report.

U. S. Death Rate Under 10.0 In 1951, 4th Straight Year

Estimates based on 10 per cent sampling of death certificates show that mortality last year was 9.68 per thousand population, fourth consecutive year in which rate fell below 10.0. In 1950 the rate (final) was 9.63. Minor increase is attributed to rise in deaths due to heart and circulatory diseases, cancer and accidents (including motor vehicle). Tuberculosis mortality dropped from 22.5 in 1950 to 19.2 last year and there were declines for syphilis, diphtheria, nephritis and nonmeningococcal meningitis. Deaths by suicide totaled 16,736, compared with 17,145 in 1950. There was a corresponding decrease in homi-

cides, from 7,942 to 7,240. Of the 32 selected causes of death listed by National Office of Vital Statistics in this comparative report, the one responsible for least mortality was typhoid fever (80 fatal cases in 1951, as against 96 in 1950).

Trend Reversed, Typhoid Cases on Increase

Reversing a trend of the last decade, typhoid fever cases are showing an increase over the totals for 1951. The figures are 2,070 cases so far this year, compared with 1,830 last. Public Health Service, releasing the information, comments that "present indications are that the total for 1952 will exceed that for 1951 and possibly that for 1950." Eighteen states reported increases over 1951 totals for the first 42 weeks of this year, five of them indicating 65 to 118 per cent higher percentages. Latest records show a continuing decline in incidence of poliomyelitis.

VA Shows Service Connection Status of Hospital Patients

Veterans Administration has done an analysis, with reference to service connection status, of its hospital patient load for month of September. Findings are important, since Congress in all probability will take up again the question of how far U. S. should go in providing medical and bed care for treatment of non service connected conditions. Of 102,613 veterans hospitalized by VA at end of September, 35 per cent were under treatment of service connected illness or injury. Next largest group, 25 per cent, were pensioners having permanent and total disabilities. Eleven per cent had service connected disabilities but were hospitalized by reason of other conditions; 8 per cent had no service connected disability, had filed no claim for compensation or pension and were undergoing treatment for tuberculosis or psychosis; 10 per cent, same as preceding except under treatment for non chronic conditions requiring less than three months' hospitalization; remaining 11 per cent divided among five miscellaneous headings.

Hill-Burton Hospital Construction Program Slowing Down

During six years, the Hill-Burton Hospital Construction program has approved 1,877 projects for federal grants totaling just over half a billion dollars. Of the 90,645 beds, about 44 per cent already are in operation, the remainder under construction or in planning stages.

The latest progress report, as of September 30, also shows that inflation and budget restrictions are rapidly slowing down the program. In fiscal 1950 a total of 537 projects were completed or on the books; the total for the current fiscal year is not expected to exceed 150.

For fiscal 1948 and 1949, the first full years of operation, appropriations were $75 million annually. In 1950, Congress increased the maximum limit to $150 million, and voted the full amount. Appropriations for the subsequent three years were $85 million, $82.5 million and $75 million. Meanwhile, construction costs per bed increased, according to hospital authorities, about 50 per cent.

The program was designed particularly to build small hospitals and in rural areas, but from the start a high percentage of the funds has gone to relatively large institutions in urban areas. On this the analysis supplied by Division of Hospital Facilities, Public Health Service, states: "Although 57 per cent of the new projects are for facilities with fewer than 50 beds, only 25 per cent of the federal funds . . . (go) . . . to these smaller facilities. A little more than half of the federal money for new hospitals assists facilities with 100 or more beds. For additions or alterations, 82 per cent of federal funds is going to hospitals with 100 beds or more." With emphasis on larger, long-range jobs (19 medical school connected hospitals on current list), reduced grants are not immediately reflected in the administrative workload, which is expected to continue at about its present level for several years.

Under the law, funds are allocated to states for distribution. Determination of what projects to assist is the responsibility of the state hospital authority, based on a survey of hospital facilities and willingness of local communities to make plans and raise money.

First Injunction Under Durham-Humphrey Drug Law

Food and Drug Administration reports the first injunction obtained under the Durham-Humphrey drug law which went into effect last spring. Defendant was the Renesol Corp. of Jersey City, a mail-order drug house, which was permanently enjoined from mailing a phenobarbital, Renesol, without a prescription. The company also will be required to

give adequate directions for use. Renesol was promoted for treatment of epilepsy. FDA said its inspectors, who placed orders without mentioning intended use, were supplied with whatever quantity they requested. Directions were said to contain neither recommended dosage nor warning that this drug was habit forming.

House Medical Bloc Shrinks

In House of Representatives, following the recent election, M.D.'s who will be back are Judd (R—Minnesota), Morgan (D—Pennsylvania), Miller (R—Nebraska) and Fenton (R—Pennsylvania). Hedrick (D—West Virginia) made an unsuccessful bid for gubernatorial nomination, giving up his House seat. Wood (R—Idaho) was defeated for reelection. House roster loses two dentists and gains one. Departures are Woodruff (R—Michigan) and Brehm (R—Ohio), both of whom retired. The addition is Long (D—Louisiana), brother of Huey Long and uncle of Senator Russell B. Long. In the other branch of Congress, sole representative of the health professions continues to be Senator Lester C. Hunt, a democrat, who has been elevated to rank of senior Senator from Wyoming as result of O'Mahoney's defeat. Among physician legislators, only Dr. Miller takes more than a casual interest in national health legislation.

FDIC Is First U. S. Agency to Furnish Health Coverage

A significant "first" was achieved in November when Federal Deposit Insurance Corporation became the No. 1 government agency to emulate private industry and give paid up health plan coverage to its employees. FDIC has nearly 1,100 salaried workers, of whom some 400 are in Washington and remainder scattered in field from coast to coast. Without cost to themselves, they will receive benefits including up to 70 days hospital coverage and liberal in-hospital medical and surgical care, on an indemnity basis. Directors of FDIC worked out the contract with Health Service, Inc., and authorized payroll deductions for accommodation of employees who strictly at their own option may wish to obtain similar coverage for dependents.

A worker desiring coverage for a spouse, or a child under age 19, will pay $3.59 a month. For family coverage, regardless of size, the rate will be $5.27 monthly. Top surgical fee is $250. Fee allowed for each in-hospital visit by attending physician is $4, with maximum of 23 visits allowable in first 19 days of hospitalization. Freedom of choice of doctor and hospital is guaranteed.

Other government agencies would like to follow FDIC's example but, with few exceptions, they can not do so unless legally empowered. FDIC gets no Treasury derived funds, receiving its operating revenue from premiums levied on banks with insured deposits, hence it needs no Congressional law to authorize a program of this kind. Federal Reserve System likewise is financed independently of public appropriations and so are a few other Federal and quasi-Federal agencies. FDIAC's lead may well influence them to follow suit, in recognition of this fringe benefit's value in the unending competition for typists and stenographers.

Too, this precedent setting contract with Health Service, Inc., may give impetus to the movement on Capitol Hill for enactment of legislation giving comparable health care coverage to all 2.5 million Federal workers, with Uncle Sam paying 50 per cent or more of the cost.

Local Blue Cross plans are participants in FDIC program, with Health Service, Inc., as intermediary, but Blue Shield conditions relating to income ceilings preclude its participation and necessitate adoption, instead, of indemnity payments for medical and surgical care.

Connecticut Academy of General Practice Holds Meeting

The Connecticut Chapter of the American Academy of General Practice held its annual meeting at the Oakdale Tavern, Wallingford, on October 16. About 100 doctors and their wives attended the dinner following the business meeting.

Election of officers for the coming year was held with the following officers elected: President, Edwin Connors, Bridgeport; President-Elect, Edward L. Douglas, Groton; Secretary-Treasurer, Peter J. Scafarello, Hartford; Board of Directors: Edward Malloy, Stamford; Sidney Chait, Torrington and R. Andrea Damiani, Waterbury; National Delegates: Michael Shea, New Haven and Michael Palmieri, New Haven.

A.M.E.F. NEWS

Fund Raising Committee
CONNECTICUT STATE MEDICAL SOCIETY

Connecticut ranks fifth among the states in the number of 1952 physician contributors to the American Medical Education Foundation.

The campaign roster lists 398 Connecticut physicians whose contributions have helped our medical schools this year.

In this last month of the 1952 campaign, every effort is being made to further advance the Connecticut record. If you have not yet contributed, you can help by using the pledge card below.



AMERICAN MEDICAL EDUCATION FOUNDATION

Fund-Raising Committee

CONNECTICUT STATE MEDICAL SOCIETY
160 ST. RONAN STREET, NEW HAVEN 11, CONNECTICUT

1. The enclosed check for $..... represents my 1952 contribution to help our medical schools.
2. Please earmark my contribution: (a) for AMEF general fund ☐
   (b) for .....
   (Name of Medical School)
3. I am already contributing directly to.....
   (Name of Medical School)

Signed: .....

Office Address: .....

.....

Date:.....

CHECK SHOULD BE PAYABLE TO AMERICAN MEDICAL EDUCATION FOUNDATION

PUBLIC RELATIONS

COMMITTEE ON PUBLIC RELATIONS

William G. H. Dobbs, Torrington
Chairman
David H. Bates, Putnam
Harold A. Bergendahl, Norwich
Harry C. Knight, Middletown
Charles E. Jacobson, Jr., Hartford
Frank C. McMahon, Stamford
Burdette J. Buck, Hartford
Morris A. Hankin, New Haven
Gaert S. Gudernatch, Sharon
John O'L. Nolan, Hartford

Plans Announced for 1953 Campaign to Aid Medical Schools

The National Fund for Medical Education has announced plans to raise five mililon dollars during 1953 to help finance medical education in the United States.

A "Committee of American Industry," composed of one hundred ranking industrial leaders, will spearhead the campaign. The Committee will conduct an educational program to acquaint industrial management with the problems and financial needs of the medical schools. This will be followed by an intensive campaign to raise contributions from 25,000 industrial and business concerns.

Concurrently with this campaign, the American Medical Education Foundation will continue its program to encourage contributions by physicians to help meet medical school needs. The State Medical Society's Committee on Public Relations is planning a 1953 program of personal solicitation to implement the national AMEF campaign in Connecticut. It is anticipated the program will be initiated early in February.

West Haven Physicians Start Emergency Call Plan

A plan to provide quick medical attention in emergencies was inaugurated in West Haven October 6 by physicians of that community.

The plan operates through the switchboard of a telephone answering service from 10 P. M. to 7 A. M. daily. Dr. John A. Chasnoff, who organized the plan, states that ten West Haven physicians are members of the rotating panel to accept emergency calls. The service is being brought to the attention of community residents through newspaper announcements and notices to town agencies. If experience warrants, the plan may later be extended to full 24 hour coverage.

The West Haven emergency system is the fourteenth community service project of this type to be sponsored by physicians in Connecticut. Recently a similar plan was announced in Milford and other plans are operating in Hartford, New Britain, Manchester, Waterbury, Bristol, Torrington, Bridgeport, Danbury, Norwalk, Stamford, Greenwich, Putnam and Norwich.

Hartford County Issues Information Directory

Recognizing the need for prompt action when news editors seek information concerning medical events, the Hartford County Medical Association has issued a directory listing seven association officers who may be consulted at any time.

The directory has been distributed to newspapers and radio stations throughout the county. It contains the names and telephone numbers of association spokesmen who reside in the principal communities of Hartford, New Britain, Manchester and Bristol. The list is headed by the telephone number of the Association's Hartford office, where most calls are first directed.

Fifth Annual PR Conference Held in Denver

The Fifth Annual Medical Public Relations Conference of the American Medical Association was held in Denver December 1 as a feature of the Association's annual Clinical Session.

Dr. Edward J. McCormick, AMA President-Elect, opened the conference with an address titled "Medical Public Relations Today," citing progress achieved and areas that will need more emphasis in 1953.

"Mutual Understanding—the Key to Better PR," was the conference theme. Subjects that received the attention of speakers and discussants included

physician-hospital public relations programs; physician-patient fee discussion practices; the economics of medical care; press-radio codes of cooperation; explaining the costs of sickness and building understanding with medical students and allied groups.

Mediation Committees Established in All States

Mediation committees have now been established by medical associations in each of the 48 states, the District of Columbia and Hawaii, according to a recent report by the AMA Council on Medical Service.

This is the result of an intensive four year program by the medical profession to establish such patient-physician relations groups. The committees are charged with investigating complaints and attempting to reach satisfactory adjustments.

Symposium on Industrial Injuries

Held at St. Mary's Hospital, Waterbury
October 9, 1952

Nearly four hundred persons attended a Symposium of Industrial Injuries held in the St. Mary's Hospital Auditorium, Waterbury, on October 9, 1952. The program was under the auspices of the Industrial Health Committee of the Connecticut State Medical Society, and was made possible through the interest and generosity of the American Brass Company. The program was attended by physicians and nurses interested in occupational medicine and by Compensation Commissioners, executive and personnel officers of manufacturing plants as well as safety directors and others interested in the overall program of industrial medicine.

The first speaker of the afternoon was Dr. David M. Bosworth, of New York City, director, Department of Orthopedic Surgery, New York Polyclinic Medical School and Hospital.

Dr. Bosworth's subject was "Differential Diagnosis and Treatment of Industrial Disabilities of the Back." The talk was well illustrated by slides and charts. He showed evidence of great experience in the field and touched not only upon the problems of diagnosis and treatment of the various back ailments, but also upon their legal and compensation significance.

The second speaker of the afternoon was Dr. Anthony F. DePalma of Philadelphia, who is professor, head of Department of Orthopedic Surgery, Jefferson Medical College. Dr. DePalma's subject was "Shoulder Injuries in Industry," illustrated with slides, emphasizing the anatomical construction of a shoulder. It showed the changes in the shoulder structures through the various decades of life. He pointed out the importance of these changes in injury and diseases of the shoulder commonly encountered in industrial practice.

The third speaker was Dr. J. William Littler, New York City, attending surgeon, Roosevelt Hospital, Plastic and Reconstructive Surgery. Dr. Littler illustrated his talk with colored slides showing how skilled surgery can be employed to give an employee a useful hand following severe trauma such as frequently seen in industry.

The afternoon session was closed by a paper by Dr. Alphonso Della Pietra, Waterbury, Connecticut, associate attending orthopedic surgeon, St. Mary's Hospital. Dr. Della Pietra spoke on the general subject of "Knee Injuries in Industry." His paper brought out many of the common conditions found in the knee joint and showed their relation to industrial injuries and discussed diagnosis and treatment.

Dr. John Gallivan, medical director of United Aircraft Corp., acted as chairman for the afternoon session and introduced the speakers.

The American Brass Company of Waterbury and Dr. Andrew J. Jackson, medical director of the American Brass Company, were hosts to the Committee on Industrial Health of the Connecticut State Medical Society and the panel speakers and invited guests at a dinner given at the Waterbury Country Club following the afternoon session.

Mr. Arthur H. Quigley, chairman of the Board of the American Brass Company, welcomed the guests and spoke briefly upon the scope and activities of this company.

The speaker of the evening meeting was Dr. Maurice Frocht, New York City, associate attending neurologist, Presbyterian Hospital, and associate neuropsychiatrist, Lenox Hill Hospital, New York. Dr. Frocht spoke on "Psychosomatic Problems in Industrial Workers Influencing Industrial Workers' Health and Accident Prevention." Dr. Frocht emphasized that industry would do well to make use of the industrial psychiatrist in their preplacement examinations and in many of their medical problems.

FROM OUR EXCHANGES

"Animal Diseases of Public Health Significance" is an instructive discussion of a problem that is only superficially understood by the average doctor. (*Annals of Internal Medicine*, 36.2.)

The problem of the relation of animal disease to human health is more complicated than most of us suspect. The author, James H. Steele, divides these diseases into three categories:

1. Animal diseases which are communicable to man. There are more than 80 diseases in this group.

2. The diseases of animals which are not a direct threat to the health of man, but do jeopardize his economic welfare (rinderpest, swine cholera, etc.).

3. Animal diseases from categories 1 and 2 which may adapt themselves to man.

The animal diseases transmissable to man have certain characteristics common to the entire group:

1. Infection in man is usually limited to the diseased individual. Person to person transmission is rare.

2. The clinical and anatomic character in man is similar to that in animals.

3. The highest incidence of infection occurs in individuals whose occupation brings them into close contact with animals or animal products.

The control of animal diseases communicable to man requires the cooperation of the physician, the veterinarian, public health departments, animal health agencies and public information services. The physician who makes the diagnosis must report the case and supply the medical history to the epidemiologist.

* * * *

In "Air Transportation of Cardiac and Pulmonary Patients" (*Annals of Internal Medicine*, 36.2) Downey et al conclude that there are no contraindications to the air transportation of cardiac or pulmonary cases in flights below 10,000 feet. Moribund cases should not be transported by air or by other means; and it is apparent that patients with certain cardiac disorders and with respiratory embarrassment will require oxygen therapy and experienced flight attendance.

The Acute Radiation Syndrome is a name applied to the group of symptoms that characterize the illness produced by radiation of the entire body or of a large part of the body. The entire issue of February (1952) of the *Annals of Internal Medicine* is devoted to this subject. The material has been arranged by more than 14 contributors under the direction of Louis H. Hemplemann.

The syndrome differs in this respect from the chronic form of radiation injury caused by repeated or protracted exposure of the body to radiation, in the fact that the illness runs an acute course lasting only a matter of weeks. If the injury is not immediately fatal the survivors may return to a productive vigorous life.

The study is based on nine cases, the result of two accidental nuclear reactions at the Los Alamos Scientific Laboratories. Since these cases at the time of the report were unique they have been reported in detail. The report is written primarily for the clinician and there is a full description of the clinical, hematologic and pathologic aspect of these illnesses.

* * * *

Best describes "The Use of an Anion-Cation Exchange Resin in Edematous States Contraindicating Mercurial Diuretics" in *American Practitioner*, 3.4. An anion-cation exchange mixture is an effective agent in the management of sodium retention edema where organic mercurial diuretics are ineffective or contraindicated. Hazards to the patient are inherent in the use of any cation exchange resin. Acidosis and over depletion of sodium and potassium are the most common dangers. These can be minimized by careful clinical and laboratory studies of the patient. The presence of renal disease need not be considered an absolute contraindication to resin therapy.

* * * *

Gale reports on twenty cases of coartation of the aorta in the *Wisconsin Medical Journal*, 51.3. A full anastomosis was performed in 19 cases. Of these 16 (80 per cent) were leading normal lives. Two patients were unimproved. One patient died. The operative mortality was 5 per cent.

Swann et al performed commissurotomy of the mitral valve on twelve consecutive cases without any mortality and with significant benefit in every case. (*Jour. Tenn. State Med. Assoc.*, 45.3). It is concluded that the patient who is disabled as a result of mitral valve disease should have the benefit of surgical treatment if the well known contraindications to the operation are observed. It is further concluded that commissurotomy of the mitral valve is a safe procedure in "our hands."

* * * *

The March issue (1952) of *Industrial Medicine and Surgery* (3) contains a report of a survey by Mallary on "Graduate Education for Physicians in Industrial Health and Occupational Medicine." In the nine universities studied, wide opportunities are available for physicians in industrial health, occupational medicine and in related fields. With a few exceptions the graduate training currently available is of recent origin and is still undergoing revision. A degree can be earned but part time study, short term courses and fellowships for a limited number of physicians seem to command the most attention.

* * * *

"Cardiac Arrest During Anesthesia" is the subject of a paper by Cassel and Elnes in *California Medicine* (76.3). The signs of cardiac arrest are listed as (1) absence of pulsation, (2) absence of blood pressure, (3) respiratory arrest, pallor or cyanosis, (4) cardiac sounds not heard over the precordium, (5) absence of bleeding, (6) direct observation of the heart, (7) dilatations of the pupils, and (8) capillary refill time may be of significance.

Of importance are the immediate steps in treatment which are listed as: notify the surgeon, lower the head of the table, stop the administration of anesthetic, and correct any situation which has possibly contributed to the emergency. Check the apparatus used in administering the anesthesia, make an accurate note of the time, start artificial respiration and, if possible, insert an endotracheal tube. During the second minute the surgeon should prepare the field for direct access to the heart. During the third minute the surgeon should proceed with the incision to gain access to the heart, and begin the rhythmical squeezing of the heart. If there is ventricular fibrillation 5 to 10 cc. of 1 per cent procaine solution may be injected into the right auricle or the left ventricle. Another method is the use of electrical stimulation of the heart as described by Beck. In a general way it is probably wise to cancel the operation after cardiac arrest or, if it must be done, a minimum procedure should be selected.

* * * *

Roy E. Moon (*Texas State Jour. Med.*, 48.3) believes that an exchange transfusion with Rh negative blood from an adult female offers the best outlook for the baby with erythroblastosis fetalis. The baby delivered from a diabetic mother should be treated as premature. Hypoglycemia can be prevented in these babies by oral feedings. The premature baby requires special attention and probably in this category are found the largest number of babies who can be saved by intelligent care.

Connecticut Tuberculosis Association 13th Annual Meeting

Mrs. M. Gilbert Burford, Middletown, was re-elected president of the Connecticut Tuberculosis Association at its 13th annual meeting, held at the New Haven Country Club, October 29, 1952. Re-elected to other offices were Henry F. Powers, Norwich, treasurer; Dr. W. Haviland Morriss, Wallingford, assistant treasurer; Dr. Cole B. Gibson, Meriden, and Mrs. Ralph D. Keeney, Somersville, as vice-presidents; Mrs. Frank B. Clarke, Fairfield, secretary. The principal speaker was Miss Mary Dempsey, statistician for the National Tuberculosis Association and formerly with the U. S. Bureau of the Census. According to Miss Dempsey a quarter of a million persons can easily be spreading the disease in the United States today. Of 1,200,000 persons who today have tuberculosis in an active or inactive stage, 400,000 need medical care and 150,000 of these are unknown to medical authorities and are undoubtedly spreading the disease. In addition, there are 115,000 persons with active tuberculosis living at home where spread of the infection is difficult to prevent.

Miss Dempsey stated, the disease is attacking 115,000 new victims a year and progress in the field of prevention is not comparable to that of treatment. At a cost of tuberculosis to the American people at well over $350,000,000 a year, it is one of the most expensive public health problems in this country today.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Barnett Freedman, New Haven
President-Elect, Mrs. Dewey Katz, Hartford
First Vice-President, Mrs. Morton Arnold, Windham Center
Second Vice-President, Mrs. Newell Giles, Darien
Recording Secretary, Mrs. Edward F. Malloy, Stamford
Corresponding Secretary, Mrs. Edward Wakeman, New Haven
Treasurer, Mrs. Norman J. Barker, Collinsville

Civil Defense

An attempt is being made in Connecticut to organize members of the Woman's Auxiliary to The Connecticut State Medical Society for Civil Defense.

Mrs. E. Roland Hill of Mystic, State chairman of Civil Defense, has been working with county presidents and County Civil Defense chairmen in an effort to organize programs for its members at local level.

Study groups on First Aid and Home Nursing have been established along with training courses for participation in Operation Skywatch. The latter is related to the Ground Observation Corps, and entails the manning of filter centers for two hour intervals. All counties have signed up members for both of these programs.

Great stress is being placed on the importance of cooperating in blood bank and x-ray programs.

Pamphlets prepared by the State Office of Civil Defense and by The Federal Civil Defense Administration are in the hands of county presidents for distribution.

A member check list is now being formulated for the purpose of classifying individuals as to their various types of specialized training, in the event they are called upon to volunteer in an emergency.

Meetings pertaining to civil defense have been held in most counties. Speakers and films have been provided for these occasions. We encourage Auxiliary cooperation with parent-teachers groups, Red Cross and other local organizations.

All members are urged to join their local Committees on Civil Defense, in order that our organization be given the opportunity to make its abilities available.

Report of County Activities

WINDHAM COUNTY

Semi-annual meeting was held October 16, Ben Grosvenor Inn, Pomfret. Guest speaker was Dr. Benjamin V. White of Hartford whose topic was "The AMA program; its contributions to the general welfare."

The Nursing Scholarship Committee has made two awards of $100 and $50 to graduates of county high schools. The Ways and Means Committee is planning a series of silver and summer theater benefits to raise funds for future scholarships.

LITCHFIELD COUNTY

Semi-annual meeting was held October 15 at the home of Mrs. Francis Gallo, Winsted. Dr. William Dobbs, Public Relations chairman of Litchfield County was guest speaker. His topic embraced "Our part as individuals in the coming election."

Buffet supper holiday party on December 11, at the Coon Club, Norfolk. Those attending will bring Christmas gifts for the Fairfield State Hospital.

This year the Fund Raising Committee will present their proceeds to the American Medical Education Foundation. This will be in lieu of the nurses scholarship awarded last year.

MIDDLESEX COUNTY

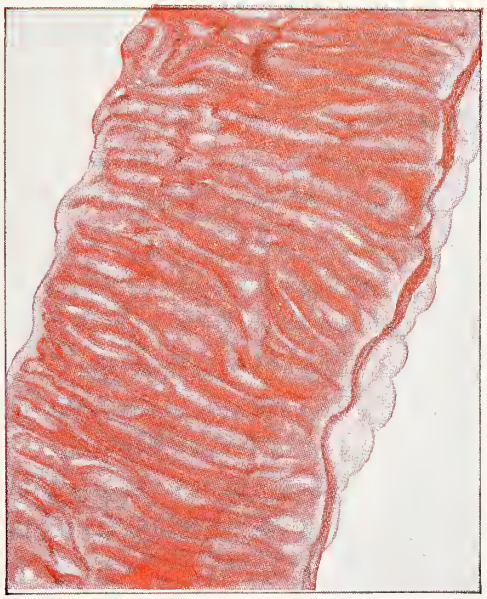
Opening meeting of the year was held at Griswold Inn, Essex, October 9. Mrs. Barnett Freedman, State president, was guest speaker. She spoke on "Auxiliary Activities."

The sale of *Today's Health* will be the project of the year. Proceeds will go to The American Medical Education Foundation. Mrs. Walter Nelson, Public Relations chairman, reported that the Auxiliary will again help in the collection and wrapping of Christmas gifts for patients at the Connecticut State Hospital.

FAIRFIELD COUNTY

The annual dance took place at the Wee Burn Country Club in Darien, on October 4. Proceeds will go to Nurses Scholarship Fund.

Promotes Normal Peristalsis— Without Injury to Mucosa



Irritated, injected mucosa such as is produced by roughage.



Mucosa remains normal following Metamucil.

Metamucil produces "a smooth, highly glistening mucosa and an increase in the tone of the bowel musculature."*

With Metamucil's "smoothage" management of constipation there is no irritation, straining or impaction—and no interference with digestion or absorption of oil-soluble vitamins.

Metamucil powder is taken with a full glass of cool liquid—producing an adequate quantity of bland, plastic, water-retaining bulk which mixes intimately with the intestinal contents and is distributed evenly through the digestive tract.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

* Block, L. H.: Management of Constipation with a Refined Psyllium Mucilloid Combined with Dextrose, Am. J. Digest. Dis. 14:64 (Feb) 1947.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

The fall meeting was held at the Red Barn, Westport, October 21. The speakers were Congressman Albert Morano, Republican, and John T. Fitzpatrick, Democratic candidates for the State Senate. They discussed their respective party's viewpoints on socialized medicine.

NEW HAVEN COUNTY

Fall meeting held October 21 at the New Haven Medical Association Library. Guest speaker, Dr. Arnold Gesell, director of the Gesell Institute of Child Development. His subject was "Some remarks on Child Development." A question and answer period followed.

The Fund Raising Committee, headed by Mrs. Steven P. Magyar, is planning to bring the Philharmonic Piano Quartet to the Shubert Theater in New Haven for a recital on Sunday evening, February 15. The proceeds of this program will be presented to the Scholarship Fund for Nurses and Medical Students. Announcements containing reservations will be mailed to members early in January.

Mrs. Donald Moore will head the committee for New Haven County in the collection and wrapping of Christmas gifts for patients at the Connecticut State Hospital. This year the Auxiliary will extend an invitation to outside organizations within the County to assist them in this project.

A Message From Your State Art Chairman

Encouraging Art in Our Membership

Dear Members:

I wish I could work more closely with all the county chairmen but since this is impossible I feel I should say a word covering my ideas about the part art can play in the Connecticut State Medical Auxiliary and in the members' families.

There is every reason why a doctor or a doctor's family should enjoy the opportunities art offers in giving added interest to their busy lives.

Our doctors are too often likely to confine themselves solely to medicine and to neglect entirely the fact that there is need for other interests.

Art opens up such varied fields of interest. There is sculpturing, ceramics, graphic arts and painting in so many different media.

Some of our busiest and finest doctors find time for art in some form with wonderful results.

It has been proven that doctors make excellent artists—as they possess the sensitiveness that is so necessary to see the true beauty in all things.

Human form is so beautiful and doctors know their anatomy so well, which is so essential in portrait painting.

Many of our doctors have become fine portrait painters.

The ability to paint the beauty of a landscape or to mold into concrete form an object of art gives much satisfaction.

Encourage your husband to take part in an art group or to continue an art interest he is neglecting. Join him in these classes or pursue an interest yourself. Your husband will enjoy your accomplishments.

It is difficult to interest a doctor to join a strange group because the group doesn't usually include the medical associates with whom he is familiar. That is just the reason he should be encouraged to join activities outside the medical field.

Attend your local art exhibitions, it's lots of fun and very enlightening. I cannot think of a more fascinating way to spend a few hours. It is not only a diversion, it is a therapy—helping to balance one's interests. It is gratifying to note the interest my husband has acquired in art since being exposed to it through my interest in painting.

We can be proud of the many talented musicians we have in our Auxiliary. We hope to hear more from them. I hope they will be willing to share their accomplishments and encourage others to join them in their endeavors. I have missed their contributions to our social affairs. I am sure that if they are approached they would be willing to give us a concert or a short recital at our dinners, luncheons, or meetings.

Our spring exhibition can and will be a great success, as it has been in the past, if we ourselves make a concentrated effort to make it so.

Look for a letter concerning the spring exhibition, and until then I wish you all a very successful and productive winter.

Most sincerely yours,
Ruth N. Waskowitz, State Art Chairman

Do You Face This PROBLEM?

Like other busy people, doctors may find there "just aren't enough hours in the day." Something must be neglected. Often it's their investments.

If you face this problem, why not find out about the Agency Account service of the Hartford National Bank and Trust Company? An Agency Account with Connecticut's oldest and largest bank relieves you of *all* the burdensome details of investment management. You have a complete record of income received and all transactions for your account . . . a great convenience at income tax time.

Investment Advisory Service

Included with your Agency Account is our Investment Advisory Service. You may, however, limit our functions to Investment Advisory Service if you prefer to collect your own dividends. This service gives you the benefit of the experienced judgment of our Trust Investment Committee in a continuing review of your investments. We would also hold your securities and arrange the brokerage transactions subject to your approval.

Cost of these services is low, and under present Federal Income Tax laws, may be deducted in determining taxable investment income. So, why not get full information, now? Ask for a copy of our booklet: "Your Financial Secretary." Call, write or use the coupon below.

Hartford National Bank and Trust Company

Established 1792

Member Federal Deposit Insurance Corporation

HARTFORD NATIONAL BANK AND TRUST COMPANY
Main and Pearl Streets
Hartford, Connecticut

Please send me a copy of the booklet:
"Your Financial Secretary"

Name .....

Street & No. .....

City or Town.....

Prescription Perfect



RED LABEL • BLACK LABEL

Both 86.8 Proof

Every drop of Johnnie Walker is made in Scotland—using only Scotland's crystal-clear spring water. Every drop of Johnnie Walker is distilled with the skill and care that comes from many generations of fine whisky-making.

Every drop of Johnnie Walker is guarded all the way to give you *perfect* Scotch whisky . . . the same high quality the world over.



Born 1820 . . . still going strong

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importer*

SPECIAL NOTICES

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

December 4

Diseases of the Gingivae and the Supporting Tissues of the Teeth

Lewis Fox, D.D.S., consultant periodontist to the Veterans Administration and assistant clinical professor of dentistry, Columbia University

December 4

Annual Dinner Meeting at Heublein Hotel, 7:00 P. M.

Evaluation of Excisional Surgery in the Treatment of Pulmonary Tuberculosis

R. Leonard Kemler, M.D., attending thoracic surgeon, Cedarcrest Sanatorium

December 11

Interesting Orosurgical Cases

Samuel Kaplan, D.D.S., attending oral surgeon, Mt. Sinai Hospital, Hartford

December 18

Differential Diagnosis of Facial Swellings

Herbert Sleeper, D.D.S., oral surgeon, McCook Memorial and Mt. Sinai Hospitals, Hartford

Meetings are held at 8:30 P. M. in the Conference Room at 95 Pearl Street, Hartford, Connecticut. All interested physicians and dentists are cordially invited.

TENTATIVE PROGRAM
NATIONAL CONFERENCE ON TRICHINOSIS
Auditorium, American Medical Association
Chicago, Illinois
December 15 and 16, 1952

CO-SPONSORS

American Board of Veterinary Public Health
American Medical Association
American Society of Clinical Pathologists
American Veterinary Medical Association
Conference of Public Health Veterinarians
United States Public Health Service
University of Michigan Phoenix Project

MONDAY, DECEMBER 15

8:30 A. M. Registration (Registration fee $5)

9:30 A. M. Welcome
Dr. George F. Lull, secretary American Medical Association

Trichinosis: A National Problem
Dr. Joseph O. Dean, Assistant Surgeon General, USPHS

Garbage-Borne Diseases in Swine
Dr. James H. Steele, veterinary director, USPHS

Incidence of Trichinosis in Swine
Dr. Benjamin Schwartz, chief, Zoology Division, Bureau of Animal Industry

Control of Trichinosis
Mr. Ralph J. Van Derwerker, chief, Municipal Sanitation, USPHS, Washington, D. C.

Economic Aspects of Trichinosis
Mr. Homer R. Davison, executive vice-president, American Meat Institute, Chicago

Trichinosis in Man
Dr. S. F. Gould, clinical professor of pathology, Wayne University College of Medicine

12:00 M. Luncheon

1:45 P. M. Low-Temperature Treatment of Pork
Dr. D. L. Augustine, professor of helminthology, Harvard University

Irradiation of Pork
Dr. Henry J. Gomberg, assistant director, Phoenix Project, University of Michigan

(Length of talks, 20 minutes)

Research, Education and Control of Trichinosis (30 minutes)
(Speaker to be announced)

Election of Permanent Chairman

3:00 P. M. First Meeting of Committees to Study Specific Problems and Formulate Recommendations
A. Public Health and Control
B. Animal Health
C. Economic problems; Legislation
D. Education
E. Research
F. Permanent organization

6:30 P. M. Dinner (Drake Hotel)

TUESDAY, DECEMBER 16

9:00 A. M. Second Meeting of Committees

10:30 A. M. Presentation of Recommendations to Conference Discussion

1:00 P. M. Adoption of Final Recommendations
Adjournment

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE
St. Louis, Missouri, December 26-31, 1952

CONFERENCE ON SCIENTIFIC EDITORIAL PROBLEMS

The Conference on Scientific Editorial Problems was organized to bring before the 119th meeting of the American Association for the Advancement of Science some of the important problems that confront those who prepare scien-



ROUGH HANDS
FROM TOO MUCH SCRUBBING?

Soothe rough, dry skin with AR-EX Chap Cream. Contains healing ingredient, carbonyl diamide. *Aids severely chapped and broken skin.* Pleasant to use. Scented or Unscented. *Send for sample.*

AR-EX COSMETICS, INC., 1036-J W. Van Buren St., Chicago 7, Ill.

CLASSIFIED ADVERTISING

$4.00 for 50 words
5¢ each additional
25¢ extra if keyed through JOURNAL
Payable in advance

CAREFUL INVESTMENT SERVICE OFFERED. Putnam & Co., 6 Central Row, Hartford—Telephone 5-1421—*New York Stock Exchange Members for 45 years,* are available for consultations on stock and bond investments, mutual fund investments, investment plans for children, etc. No extra supervisory fees. *Ask for Albert Putnam.*

FOR SALE—Refinished Guaranteed Medical Equipment, etc. At a Savings Up to 75%. HYFRECATER $27—BAUMONOMETERS and TYCOS MERCURIAL PRESSURE $20 up—DIAGNOSTIC sets $22 up—New X-ray VERTICAL CASSETTE HOLDER $25—New KELEKET 10 x 12 CASSETTE and PATTERSON PAR SPEED SCREENS $32—used 8 x 10 CASSETTES and PAR SPEED SCREENS $12—PATTERSON FLUROSCOPIC B SCREEN 11 x 14, $15—New WOLF Combination Dark Room Light $8—Lead Rubber Aprons $8.50—GOMCO CIRCUMCISION set, four sizes $25—HALSTEAD STAINLESS MOSQUITO FORCEPS $2.25—HEMACYTOMETERS $5—New SPENCER CALIBRATED mechanical stage $45—Aluminum splints 50¢—EXAMINING LAMPS $22 up—EENT instruments, LAFORCE, DANIELS-SLUDER-BALLINGER GUILLOTINES—BECK-SCHENK TONSILLECTOMIES-ADENOTOMES—RECTAL and GYN instruments—BONE RONGEUR FORCEPS—Phone Meriden 5-9675 or write HARRY SACKER, P. O. Box 642, MERIDEN, CONN.

FOR SALE—Refinished Guaranteed Medical Equipment at a savings up to 75%. Refinished instrument cabinets $50 up—Refinished examining tables with new reversible leatherette padded cushions, chrome stirrups, $50 up—Cabinet model examining and treatment tables $175—Hamilton Walnut wood examining and treatment room furniture, in excellent condition at a tremendous savings—large desk and chair $65—deluxe specialists chairs for EENT work, practically new $65 and $75—IRRIGATOR stand outfit $25—MICROSCOPES — STERILIZERS — INSTRUMENTS — SHORT WAVE, FCC LICENSE—Phone Meriden 5-9675 or write to HARRY SACKER, P. O. Box 642, MERIDEN, CONN.

In very special cases
A very superior Brandy



Specify 84 Proof

★ ★ ★

HENNESSY

THE WORLD'S PREFERRED
COGNAC BRANDY
Schieffelin & Co., New York N.Y.

Made stronger to last longer

E&J FOLDING WHEEL CHAIRS



- Chrome plated
- Comfortable
- Easy handling
- All welded joints
- Accessories and modifications available

See your dealer or write for catalog

FOLDS TO 10-INCHES

EVEREST & JENNINGS
761 No. Highland Ave., Los Angeles 38, Calif.

tific manuscripts, who are concerned with the preparation of technical reports, or who edit and produce scientific publications. It is contemplated that conferences on these subjects may become a permanent feature of the annual meetings of the Association. Program Chairman: Marian Fineman, chief, Editorial Branch, Technical Operations, Dugway Proving Ground, Tooele, Utah.

PROGRAM

SUNDAY AFTERNOON, DECEMBER 28

2:00 P. M.; Room 4B, Kiel Auditorium;

Conference on Scientific Editorial Problems

Marian Fineman, Presiding

1. Standardization of Literature Citations
   A. J. Riker, University of Wisconsin
2. Offset Lithography
   Jacques Cattell, Science Press, Lancaster, Penn.
3. Role of Statistics in Technical Reports
   Gertrude M. Cox, North Carolina State College
   Intermission
4. Problems of Documentation in the Department of Defense
   Leslie Neville, Armed Services Technical Information Agency, Department of Defense
5. Format of Technical Reports
   George Sielstad, Applied Physics Laboratory, The Johns Hopkins University, Silver Spring, Maryland
6. Technical Reporting in a Naval Research and Development Establishment
   A. E. Tyler, U. S. Naval Ordnance Test Station, China Lake, California

THE NEW YORK INSTITUTE OF CLINICAL ORAL PATHOLOGY, INC.

The New York Institute of Clinical Oral Pathology announces a meeting which will be open to the dental, medical and allied professions in celebration of its Twentieth Anniversary to be held in Hosack Hall, The New York Academy of Medicine, 2 East 103rd Street, on Monday evening, January 12, 1953 at 8:30 P. M.

For the occasion we have invited Dr. Charles S. Cameron, medical and scientific director and vice-president of the American Cancer Society, Inc., to be our essayist on the subject, Cancer: Retrospect and Prospect.

POSTGRADUATE COURSE

Measurement of Pulmonary Function in Health and Disease

The American Trudeau Society, medical section of the National Tuberculosis Association, announces a Postgraduate Course on the "Measurement of Pulmonary Function in Health and Disease," to be sponsored by the medical schools of Harvard University, Tufts College, and Boston University, and to be held in Boston from March 23 to March 27, 1953 from 9:00 A. M. to 5:00 P. M. daily.

This is a beginners course aimed at physicians interested in diseases of the chest who wish to acquaint themselves with the ABC's of methods used in the evaluation of pulmonary function. Mechanical methods of analysis of pulmonary function and related cardiac function will be described. Actual hospital demonstrations of tests with patients will be carried out.

Tuition fee is $50. Applications and more detailed information may be obtained from Edward J. Welch, M.D., chairman, Regional Committee on Postgraduate Courses, 1101 Beacon Street, Brookline 46. Massachusetts.

Tuberculosis associations in Connecticut will provide a limited number of scholarships upon request. Information regarding scholarships may be secured through Mabel Baird, executive secretary, Connecticut Tuberculosis Association, 43 Farmington Avenue, Hartford, telephone 7-9206.

PRIZE FOR PAPER ON DIABETES

The American Diabetes Association offers a $250 prize to medical students and interns for a paper on any subject relating to diabetes. The paper can be a report of original studies, a biographical or historical note, a case report with suitable comment, or a review of the literature.

This incentive is particularly apropos in the field of diabetes, since Dr. Paul Langerhans made his studies of the pancreas, describing the islets that bear his name, while he was an undergraduate student in Berlin in 1869; and Dr. Charles H. Best, while a graduate student was co-discoverer of insulin in 1922.

Manuscripts must be submitted on or before April 1, 1953 to the editorial offices of *Diabetes:* The Journal of the American Diabetes Association, 11 West 42nd Street, New York 36, New York. The papers will be reviewed by the editorial board, which will take into consideration the value of the material and method of presentation in selecting the best paper.

The award of $250 has been made possible through the generosity of the St. Louis Diabetes Association, an affiliate of the American Diabetes Association.

AMERICAN ACADEMY OF OB-GYN. HOLDS FIRST CLINICAL SESSION

The First Annual Clinical Session of the American Academy of Obstetrics and Gynecology will be held December 15-17 at the Palmer House, Chicago.

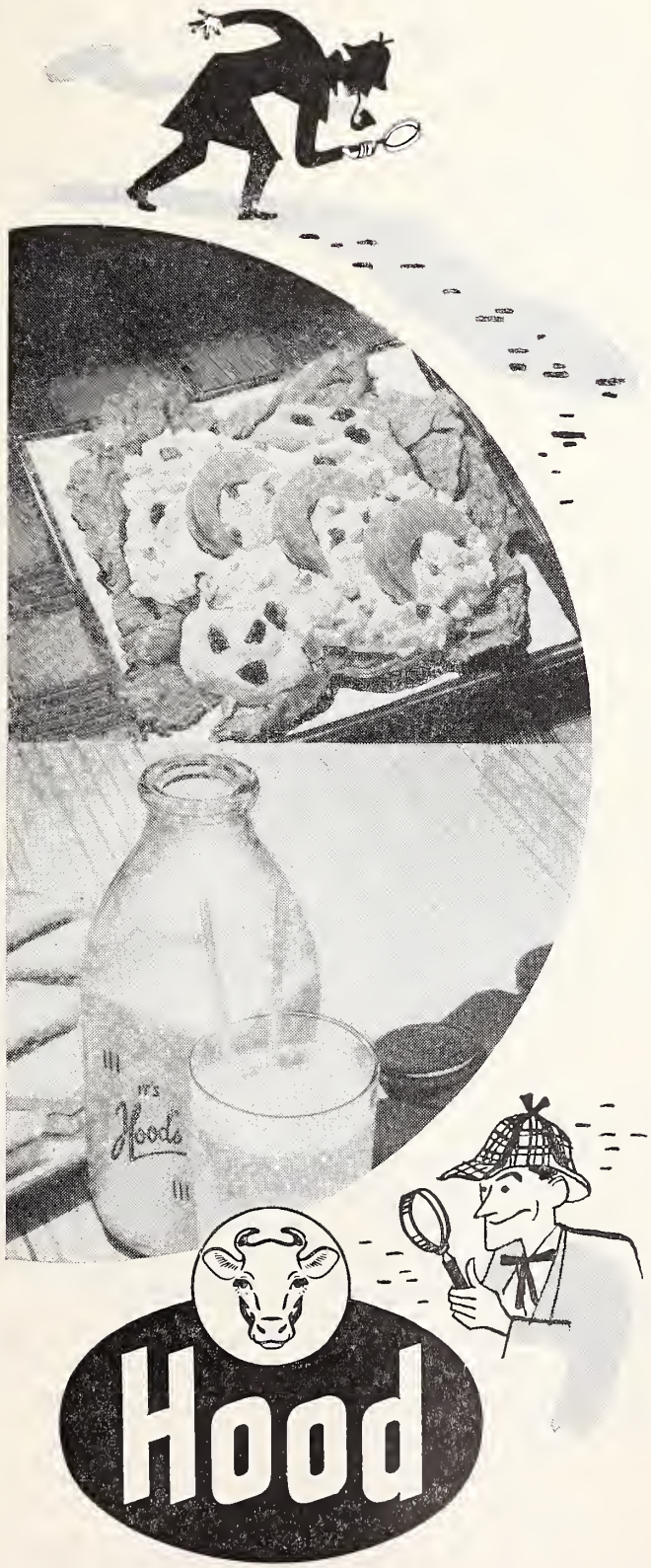
The meeting will feature six general sessions and 48 discussion groups of 40 Fellows each. There also will be at least 15 new scientific exhibits and about 60 technical displays.

The annual banquet Tuesday evening, December 16, will feature an address by the retiring president, Carl P. Huber of Indianapolis. The first truly national organization in its field, the Academy was incorporated August 14, 1951 and already has some 2,400 qualified Fellows.

Election of officers will take place at the annual business meeting Tuesday morning.

Program chairman is Ralph A. Reis of Chicago.

The Case of the Missing Elements



Can you imagine a reducing diet in which carbon, hydrogen, oxygen, nitrogen, sulphur and phosphorus — the main elements contained in Proteins — are missing?

HERE ARE 2 VALUABLE HIGH-PROTEIN, LOW-FAT REDUCING FOODS

Hood Nonfat Cottage Cheese

has an exceptionally high concentration of proteins, plus a high calcium content.

Hood Sil-ou-et Nonfat Milk

contains the protein and most of the other essentials of whole milk, but only .005% of the fat. Also available in many areas . . . Hood Cherry Hill Nonfat Milk.

For Consistently High Quality, you can recommend these diet foods with complete confidence.

Hood

Quality Dairy Products Since 1846

OUR NEIGHBORS

Massachusetts

Henry R. Viets, a prominent neurologist in Boston and chairman of AMA Council on Scientific Assembly, was elected chairman of the new Armed Forces Medical Library organization at its first meeting in Washington in October.

NEWS
from County Associations

Fairfield

John William Vollmer, a practising physician in Norwalk for 47 years, died at his home in Wilton on October 16 at the age of 68 years.

The New Milford Times is the authority for the statement that New Milford is to have two new additions to its roster of physicians in the near future. Noah Barysh of New York City will engage in the practice of pediatrics and allergy and Jeffrey Ferris, also of New York City, in the practice of surgery. These two young physicians are said to be attracted to New Milford by the excellent hospital which is in operation in that town.

Louis Newton an obstetrician and gynecologist with offices in Bridgeport, died at his home in Fairfield on October 18 after a long illness.

William Kaufman of Bridgeport has been appointed to the Editorial Board of the International Archives of Allergy and Immunology. Dr. Kaufman's article, "Should Doctors Tell the Truth," will be published in the January issue of *Coronet*.

* * * *

Attending the Post Graduate Assembly in Boston in October were Jacques V. Voris of Darien, Robert M. Steel of Stratford and Edwin R. Connors of Bridgeport, the latter as the representative of the Connecticut Academy of General Practice from the State of Connecticut.

* * * *

Milton M. Lieberthal of Bridgeport and Nathan H. Friedman of Stratford attended the International Medical Assembly in Cleveland in November.

The November monthly meeting of the Bridgeport Medical Association was held in the auditorium of Bridgeport Hospital on November 11, presided over by the president, Mark I. Gildea, Jonas H. Sirota, instructor in Postgraduate Medicine at Columbia University Medical School, delivered a paper on, "Current Concepts The Pathogenesis and Treatment of Acute Renal Insufficiency."

* * * *

At a recent meeting of the staff of Bridgeport Hospital it was voted to establish a Department of General Practice in the hospital.

* * * *

Marvin Lillian, formerly of New Haven, has been appointed Medical Director of Education at the Bridgeport Hospital.

* * * *

Frederick P. McIntyre of Stamford has resumed practice in Stamford after his recent discharge from the army.

Hartford

Hartford County's 867 member medical association at its semi-annual meeting in Bristol last month approved a new by-law which will attempt to regulate excessive fees in controversies between patients and member-doctors.

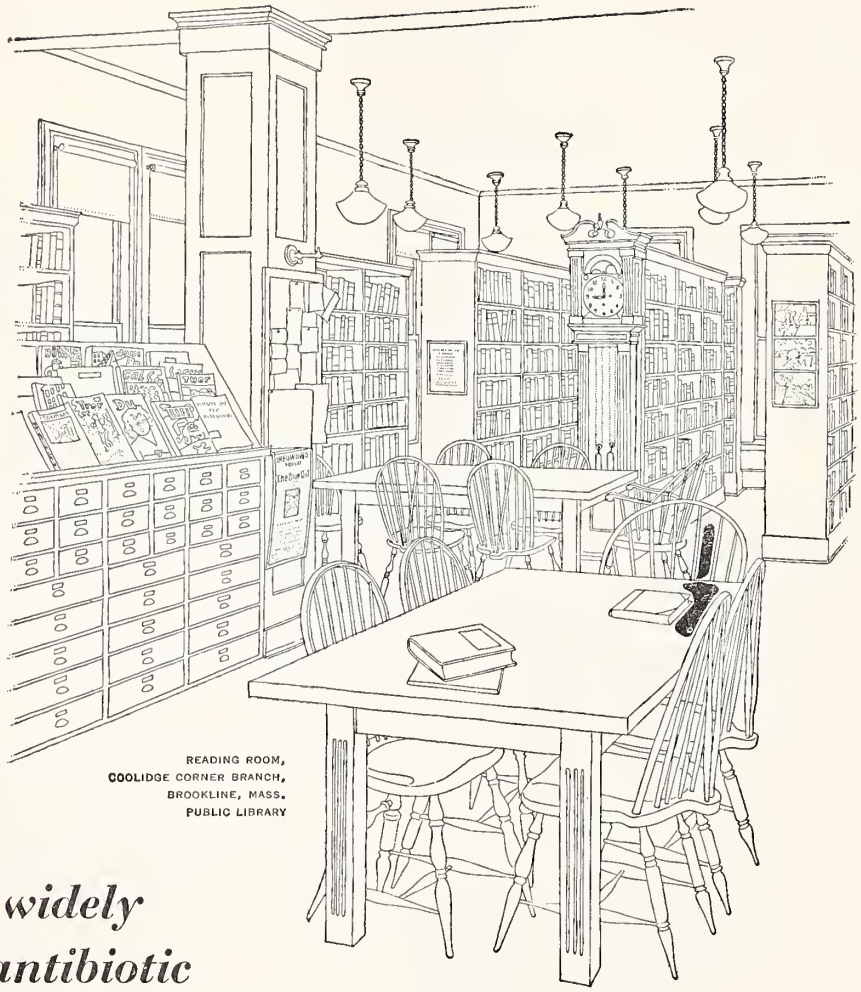
This new addition to the by-laws will strengthen the powers of the Committee on Medical Ethics and Deportment. Hartford County is the first of the State's eight counties to give its officials these powers.

The by-law reads: "When a matter in controversy relates to the fee charged by a member of the Association, the committee shall hold a hearing and by majority vote, determine the fee which it deems fair and proper, after seeking the advice of three physician members, who are recognized specialists or practitioners in the field concerned. Failure of the member to agree to such determination of the committee, or, having agreed to the amount so fixed, failure of the member to abide by his agreement, shall constitute grounds for the preferring of charges of unprofessional conduct.

"The committee shall then report its findings and conclusions to the Board of Directors."

In practice, the board of directors could refer the matter to the State Department of Health which, in turn, could prefer formal charges for considera-

New aureomycin minimal dosage for adults —four 250 mg. capsules daily, with milk.



READING ROOM,
COOLIDGE CORNER BRANCH,
BROOKLINE, MASS.
PUBLIC LIBRARY

a most widely accepted antibiotic in the broad-spectrum field is

AUREOMYCIN

Hydrochloride Crystalline

because

Physicians in the United States and throughout the world have recognized the time-saving value of immediate use of aureomycin in cases of active infection.

The successful use of aureomycin, as described in publications by physicians throughout the world, has increasingly encouraged others to use this antibiotic and publish reports thereon. To date, more than 7,000 original reports, editorials, brief comments, and similar notations have appeared in the published literature.

The trend of the literature clearly indicates that in desperate situations caused by infection, where previously cure would have proved difficult or impossible, aureomycin has saved the day.

Capsules: 50 mg.—Vials of 25 and 100. 100 mg.—Vials of 25 and bottles of 100. 250 mg.—Vials of 16 and bottles of 100.
Ophthalmic Solution: Vials of 25 mg.; solution prepared by adding 5 cc. distilled water.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY 30 Rockefeller Plaza, New York 20, N. Y.

tion by the Connecticut State Medical Examining Board, which has the power to revoke or suspend a physician's license or reprimand him.

State referee Arthur F. Ells of Litchfield, a former justice of the State Supreme Court of Errors praised the profession for its service to humanity, but advised that doctors steer away from medical jargon when appearing as witnesses in court.

William H. Upson, president of the County Association, reported the admission of 34 new members.

* * * *

At the October meeting of the board of directors Miss Doris Chandler, executive director of the Hartford Heart Association, Mrs. Helen Russell, executive secretary of the Hartford branch of the Connecticut Cancer Society, and Mr. Frederick Kelley, executive secretary of the Greater Hartford Health and Tuberculosis Society, outlined the programs of their respective organizations.

The board of directors of HCMA has authorized the executive secretary to employ a full time secretary to assist him in the execution of his duties.

* * * *

HCMA distributed in its October *Newsletter* a striking four page pamphlet called "Diabetes—its detection—its control." A few days later the Woman's Auxiliary visited county doctors with these folders, asking the doctors to insert them along with November bills. More than 20,000 pamphlets were handled by the Woman's Auxiliary.

* * * *

HCMA working with the Greater Hartford Public Health and Tuberculosis Society worked out a program of health education at the Hartford and West Hartford high schools last month. Courses included (1) Keeping Slim and Fit—Dr. Wilson Fitch Smith; (2) Inside Information on New Drugs—Dr. Joseph F. Jenovese; (3) Bright Years Ahead—Dr. James S. Missett; (4) Maintaining Mental Balance—Dr. John Donnelly; (5) Good Senses—Dr. W. Allen Donnelly (Hartford) and Dr. Walter Keefe (West Hartford); (6) Cancer—Dr. David Robinson.

* * * *

Booklets prepared by the TB Society have also been distributed in West Hartford and Newington, offering organizations in those areas health education programs. When a selection of topics is made by any organization, HCMA will provide a speaker.

Last month the Woman's Auxiliary sent out teams to every major theater outlet in the county, asking that theater managers exhibit the film "Your Doctor."

* * * *

Manchester Medical Association held its annual fall meeting in October at the residence of D. J. Roberts in Bolton. New officers elected were Jacob Sigal, president; Joseph Massaro, vice-president and Joseph Barry, secretary. Thirty-eight physicians attended.

* * * *

The new officers of the medical and surgical staff of the Hartford Hospital elected at the annual meeting on October 22 are Hartwell G. Thompson, president; G. Gardiner Russell, vice-president; Louis F. Middlebrook, secretary; and to the executive committee for three years Robert G. Reynolds, Philip G. McLellan, Maurice T. Root and E. Myles Standish.

Thacher W. Worthen, former president of the staff, and Wilmar M. Allen, director of the hospital, presented the staff with a black walnut gavel made from the original stair rail in the old hospital building demolished in 1948. This gavel was used by the president, Stanley B. Weld, during the annual meeting and then presented in turn to the incoming vice-president, Dr. Russell, in the absence of the new president, Dr. Thompson.

* * * *

Hartford suffered the loss of one of its most promising young physicians when poliomyelitis claimed the life of Dwight Griswold on November 6 at the age of 35 years. Dr. Griswold, in addition to carrying on a private practice, was director of medical education at McCook Memorial Hospital. Many Hartford physicians attended the funeral held in the Old Lyme Congregational Church and conducted in part by Rev. Henry Sloane Coffin of New York City.

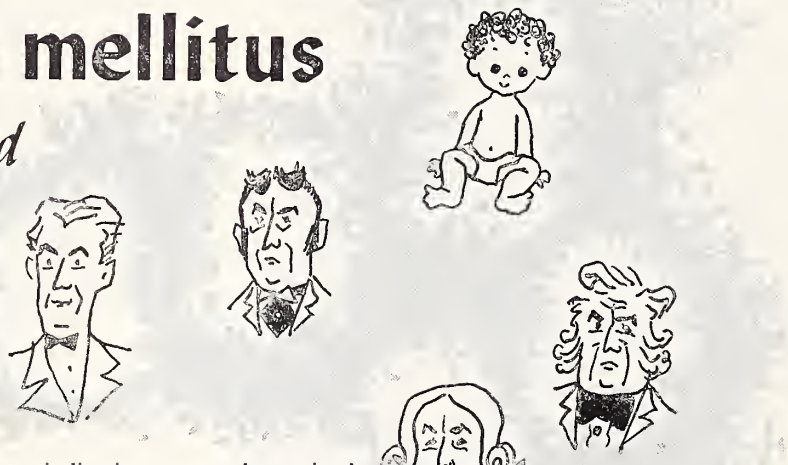
* * * *

Ralph M. Tovell is the recipient of the distinguished service award for 1951 presented by the American Society of Anesthesiologists at its recent annual meeting in Philadelphia.

Litchfield

The 188th semi-annual meeting of the Litchfield County Medical Association was held at the Tor-

"diabetes mellitus *shows a marked familial tendency"*[1]



the diabetic family

Every case of diabetes is a clear indication to test the patient's relatives for evidence of the "pronounced inherited susceptibility to the development of the clinical form of the disease."[1] Early diagnosis makes possible the early control and continuous treatment that are "of the greatest importance in reducing the incidence and severity of degenerative complications."[2]

diabetes in children

Testing for diabetes is especially indicated in children and youthful members of diabetic families, since "the age at onset is earlier in those cases with positive family histories of diabetes."[1] Prompt control is a significant factor in postponing or preventing vascular complications—now responsible for more deaths and debility than all other causes in patients with onset of diabetes early in life.[2]

CLINITEST

BRAND • REG. U.S. PAT. OFF.

for urine-sugar detection

Detection of urine-sugar is simple, reliable and rapid with *Clinitest* (Brand) Reagent Tablets. The results are directly read. No external heating is needed. *Clinitest* is excellent for office and clinic, and for diabetic patients.

1. Watson, E. M., and Thompson, M. W.: Am. J. Digest. Dis. *18*:326, 1951.
2. Wilson, J. L.; Root, H. F., and Marble, A.: J.A.M.A. *147*:1526 (Dec. 15) 1951.

AMES COMPANY, INC. | ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

C-3

rington Country Club, on October 7. The president, Dr. Thomas J. Danaher, presided.

The principal business of the evening was a discussion of a report from the Executive Committee which recommended the formation of a committee on nonoccupational health accident insurance. The proposed committee is to function as an arbitration committee in any disputed nonoccupational health accident claim called to its attention, either by industry, a physician or a claimant. After considerable discussion, the matter was tabled pending further study by the Executive Committee.

The speaker of the evening was Mr. Harry B. Purcell, Industrial Relations manager, Torrington Company. His subject was "The Third Party In a Physician's Office." He gave a very interesting talk and quoted figures to illustrate new problems facing industry as a result of nonoccupational health accident insurance carried by many industries for the benefit of their employees. He showed that industry has a very definite and valid thirty party interest, particularly in the Torrington area as all the industries in this area pay the entire cost of this insurance.

The following physicians were admitted to membership by transfer from other medical societies: Francis E. Tierney, Albert Sterling Atwood, and John Louis Meunier. The new members admitted were Thomas Morton Hart, Margaret Stanley-Brown and Jeffrey Ferris.

Middlesex

F. Erwin Tracy was in Boston for three days the latter part of October to attend the sessions of the New England Post Graduate Assembly.

* * * *

The semi-annual meeting of the Middlesex County Medical Association was held at the Griswold Inn, Essex, on October 9. The meeting, for a change, started promptly at the scheduled time. Harry Knight reported that a booklet describing health facilities in Middlesex County was being prepared and it was planned to give it general distribution, particularly to new arrivals in the community.

Carl Chase reported that the Civilian Defense medical branch had apparently expired.

Harry Whiting brought up the names of three physicians as applicants for membership. The new members are: Donald Arnault, who practices surgery in Middletown; Alfred Owre, who is engaged in general practice in Madison; Herbert Levine, who is doing internal medicine in Middletown.

Following the business session, the members were joined by their wives for a social hour. After dinner Mr. Hyman Haves presented an audience participation program on "The Psychology of Rumors."

New Haven

Samuel Climo of New Haven has been officially certified as a diplomate of the American Board of Plastic Surgery and invited to full membership in the American Society of Plastic and Reconstructive Surgery.

At the Sterling Hall of Medicine on October 22 the faculty of the Yale University School of Medicine was invited to the gymnasium at the Sterling Hall of Medicine to meet the new dean of the Yale Medical School, Dr. Vernon W. Leppard.

* * * *

On November 5 Stanley Gilbert, consulting surgeon of the Mt. Sinai Hospital, New York, spoke on the "Surgical Considerations in the Treatment of Infection and Gangrene in the Diabetic." This meeting was held at the New Haven Medical Society.

* * * *

On November 19 at the New Haven Medical Society Richard Cattell from the Lahey Clinic spoke on "Surgical Diseases of the Thyroid."

* * * *

A committee appointed by the president of the New Haven City Medical Society has been actively engaged in drawing up definitive plans for emergency night calls in the greater New Haven area.

A report was made but the plans have not been completely arranged and the coverage was to be set up on the first of November.

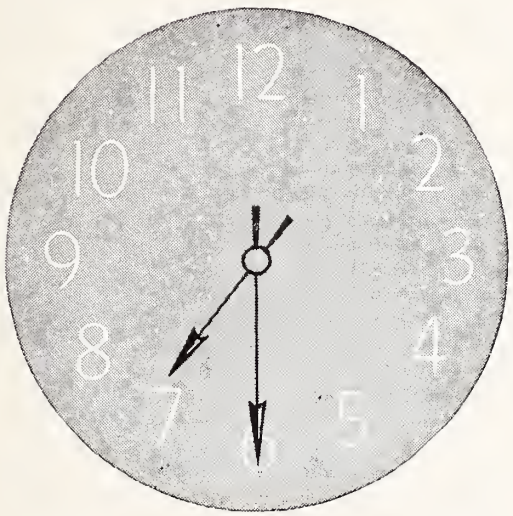
* * * *

David M. Little, Jr., L. Jennings Hampton and Mary Louise White, all of New Haven, are the authors of "Asphyxia Neonatorum: The Syndrome, Its Prevention and Its Treatment" published in *Anesthesiology*, September 1952.

* * * *

Thomas P. Murdock of Meriden, AMA trustee, addressed the Postgraduate Course in Chronic Illness at the University of Oklahoma in June on the subject, "Cardiovascular Disease as a National Health Problem." Dr. Murdock's manuscript was published in the *Journal of the Oklahoma State Medical Association* in October.

William J. German of New Haven is the new president of the Harvey Cushing Society.



habit time

- Habit Time of Bowel Movement—not merely relief of constipation—is secured by proper use of Petrogalar.

Petrogalar promotes development of normally hydrated, comfortable and easily passed stools.

Once achieved, the normal bowel habit may often maintain itself even though the dosage of this adjuvant is slowly tapered off.

PETROGALAR®

AQUEOUS SUSPENSION OF MINERAL OIL, PLAIN

Supplied: Bottles of one pint

Wyeth®

News from Yale University School of Medicine

Theodore Lidz, professor of psychiatry, was appointed as Psychiatrist-in-Charge of the Yale Psychiatric Clinic on September 1, replacing Edward Stainbrook, who has left to become professor and chairman of the Department of Psychiatry, School of Medicine of the State University of New York at Syracuse. Dr. Lidz's interest and experience enables the Clinic to provide care and therapy for patients with psychosomatic problems with the aid of the medical staff of the Medical School, in addition to offering treatment and care to all types of psychiatric patients.

Provision has been made to enable the Clinic to assist those patient who require long term hospitalization for intensive psychotherapy. The University has arranged means of sharing the expenses for some patients if financial difficulties would otherwise terminate their stay in the Clinic. In addition, the financial means of patients need no longer limit admission policies as rigidly as in the past.

The Clinic is also interested in briefer therapies and in diagnostic problems. The interest in psychotherapy with schizophrenics continues and research funds are being devoted to the study of such patients.

* * * *

On October 10 a problem case of exophthalmus in a forty-one year old white female was presented by R. M. Fasanella, at the Yale Postgraduate Series. This marked bilateral exophthalmus followed a thyroidectomy and was carefully followed by both the Boston and New Haven Group. John P. Peters, professor of medicine at Yale University School of Medicine, discussed the medical aspects of this case; William German, professor of neurosurgery, covered the indications for neurosurgical intervention and the technique; Dr. Chu H. Chang, in charge of radio therapy, enumerated what the radiologist could offer.

* * * *

On October 31 Joseph Igersheimer of Boston was guest speaker. His subject was "Rheumatism and the Eye." He gave a histological, pathological, and clinical presentation with many colored slides. Numerous questions were asked of the speaker with the principal comments being made by Dr. Eugene M. Blake, Dr. Arthur Yudkin, and Dr. I. K. DiSuto-Nagy. The difficulty in distinguishing "tuberculous" and "rheumatic" iritis and iridocylitis was stressed and a clinical and experimental differential was outlined. The speaker was introduced by J. Alexander VanHeuven.

NEW BOOKS IN REVIEW

SURGERY AND THE ENDOCRINE SYSTEM. PHYSIOLOGIC RESPONSE TO SURGICAL TRAUMA—OPERATIVE TREATMENT OF ENDOCRINE DYSFUNCTION. By James D. Hardy, M.D., F.A.C.S. *Philadelphia: W. B. Saunders Company.* 1952. 153 pp. $5.

Reviewed by Samuel C. Harvey

This is a concise and informative volume written by a young surgeon, now assistant professor of surgery at the University of Tennessee. He is representative of an increasing number of surgeons who have acquired their training in institutions where acquisition of clinical knowledge and skill is happily combined with the understanding to be gained from working in a research laboratory in the basic sciences of medicine. In this instance the clinic is that of the University of Pennsylvania Hospital and the laboratory that of the Harrison Department of Surgical Research, both under the direction of Professor Ravdin.

Obviously the content of this book represents that which the author has acquired under these circumstances, in a field that in the past ten years has expanded tremendously in large part due to the interest of the physiologists and the internist and in which the function of the surgeon has been in considerable part that of the handmaiden. The objective of Dr. Hardy is that of bringing to the surgeon, as clearly and simply as possible, the relatively recent advances in the field of endocrinology.

As a result, about one-third of the text discusses the physiology of the endocrine glands in relation to basic problems of surgery, such as "The Alarm Reaction," "Body Fluid Regulation," "Nutrition," "Early Ambulation" and "Tissue Repair." The remainder is occupied by consideration of "Endocrine Therapy" and the major endocrine glands. In this part the presentation is more that of a compendium that would be of particular value to a resident staff. It is nevertheless well worth reading as a "refresher" to those of a more ancient vintage.

While it is apparent that this book is one that most surgeons could read with pleasure and benefit, it nevertheless covers the large field in an abbreviated manner. It is excellent as a springboard but cannot relieve one of the necessity of a more time consuming approach, namely, that of study of the voluminous literature in this field. The author has anticipated this by a large but critical list of references, distributed according to chapters. There is also a comprehensive subject index at the end of the volume.

PROVED effective in three years' clinical use

Cortone®

ACETATE
(CORTISONE ACETATE, MERCK)



Typical experience:

Administration of CORTONE,
systemically, reduced rheumatoid arthritis symptoms
in *all* of 100 patients treated.
Daily maintenance doses of 50 mg. or less, orally,
were adequate in 53 per cent of cases.

Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. **26**: 361, Sept. 26, 1951.

CORTONE is the registered
trade-mark of Merck & Co., Inc.
for its brand of cortisone

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY
In Canada, MERCK & CO. Limited—Montreal

© Merck & Co., Inc.

CLAUDE BERNARD & THE EXPERIMENTAL METHOD IN MEDICINE. By J. M. D. Olmsted, Professor of Physiology at the University of California. Membre correspondent de la Societe philomathique de Paris. Pris Binoux, Academie des Sciences, 1949 and E. Harris Olmsted. *New York: Henry Schuman.* 1952. 277 pp. $4.

Reviewed by Stanley B. Weld

To the embryo scientist this account of the life of the great physiologist, Claude Bernard, should serve as an inspiration; to the practising physician the contribution of a French country lad to medical science should provoke a deep sense of gratitude; and to the lay reader there should be apparent the lesson of perseverance and thoroughness which characterized this great life. Claude Bernard was not born with a silver spoon in his mouth. His father was a simple French provincial, descended from a long line of vine-growers and his world possessions consisted, beside the farmhouse, of two vineyards on Chatenay hill overlooking the village of Saint Julien-en-Beaujolais which he received as a part of the dowry of his nineteen year old bride. So strongly did this setting on the slopes of the Saone River impress itself on the life of young Claude that in his later years scarcely a vintage season passed but he returned to his native town. He loved the scene of his boyhood days.

The life of Claude Bernard was not cut in a clear and definite pattern with science the goal and ambition from the start. Educated by the local clergy, he was sent to college at the age of seventeen presumably as suitable material for the church. Finances brought his college education to an end and he turned to eking out a living as a pharmacist's apprentice. It was at this time he began to write plays, lost interest in his work in the pharmacy, and finally arrived in Paris with his play, "Arthur of Brittany," under his arm.

The story of his shift to medical school, his developing interest in experimental work, his meticulous anatomical dissections, and even as an intern his work as assistant to the famous Francois Magendie, pioneer French physiologist, is an intensely interesting one. The authors have done an excellent job in putting life and action into their biography and adding color and sentiment, drawn from an environment which produced a simple man, passionately dedicated to his work to whom the world owes much.

The list of Bernard's accomplishments are interestingly recounted. He clarified the role of the pancreas in digestion. He studied the place of the liver in sugar metabolism, isolating glycogen. He investigated the action of curare and discovered just how this action took place. His crowning achievement was the publication of his "Introduction to the Study of Experimental Medicine." This was intended as an introduction to"Principles of Experimental Medicine," which was never completed but published in notebook form finally in 1947.

Claude Bernard had two objects in his later years: one, to emphasize the vital point of view in doing his experiments; the other, to establish the true relationship between experimental physiology and scientific medicine.

Like the other volumes in Schuman's Life of Science Library, this one is simply but well bound, the type is very legible, and at the end is included a list of bibliographical references arranged by chapters. You should enjoy reading it.

VIRAL AND RICKETTSIAL INFECTIONS OF MAN. (2nd edition) *Edited by Thomas M. Rivers,* M.D., Director of the Hospital of the Rockefeller Institute for Medical Research. *Philadelphia: J. B. Lippincott Co.,* 1952. 719 pp. $7.50.

Reviewed by John R. Paul

The first edition of this book which appeared in 1948 proved to be a landmark in the field of infectious diseases in this country and it is not surprising therefore, that the demand for a second edition came promptly. From the beginning "Rivers'" book proved to be more than a text on microbiology for it is concerned with much more than the properties of viruses and rickettsiae which are pathogenic for man. It also deals with clinical aspects of the diseases which these agents produce. Thus it was prepared not only for medical students as a text to be followed in their courses of microbiology, but as a book which could be useful to them during their clinical and intern years, and one for which a place might be found on their book shelves when they enter practice. This is reflected by the fact that the technical information and methods of handling viruses are dealt with in only a third of the book's contents. The rest deals with other aspects of this big subject, including a certain amount of modern "philosophy" about infectious disease in general, and virus and rickettsial diseases in particular.

Few subjects in medicine have expanded more rapidly than has this particular field during the past five years, and this second edition of "Rivers" which is here reviewed, bears witness to that fact. From a volume of 580 pages it has grown to one of 720 and it now represents an up-to-the-minute and dependable source book in which 30 contributors have joined under a distinguished author. Nearly all of the chapters have been rewritten and enlarged. There is a completely new chapter on the recently discovered Coxsackie viruses which reflects the speed with which the virus field is expanding for it describes here a family of viruses with some 20 members, none of which had even been discovered at the time of the appearance of the first edition. New chapters are also included on hemagglutination by viruses, and interference between animal viruses. Perhaps the most practical chapter in the book is the one on the diagnosis of virus and rickettsial infections in which five distinguished investigators have joined their efforts.

It should be remembered that Dr. Rivers was an early champion of viruses and viral diseases and has special qualifications to edit a volume of this kind. He grew up with this science in this country, having started to work on viruses pathogenic for man when he first went to the Hospital of the Rockefeller Institute in the early 1920's at a time when viruses as a cause of human disease were receiving scant attention indeed. Today viral and rickettsial agents represent what has become a most important group of etiologic agents responsible for some of the commonest as well as some of the most serious of our acute infectious diseases. There is no longer anything exotic about virus infections. They have become a household word.



RELAXED . . . *but awake*

In the many cases which require sedation without excessive hypnosis, Mebaral is of outstanding merit.

With its relatively wide margin between sedative and hypnotic dosage, Mebaral may be employed in those conditions in which relief from anxiety, depression or agitation is desired during the waking hours.

INDICATIONS:
Mebaral affords alleviation of tension in the hyperthyroid or hypertensive patient, relaxation in neuroses and mild psychoses, a calming influence in the high-strung menopausal patient. It is also a reliable anticonvulsant in epilepsy.

Mebaral®

TASTELESS TABLETS
Tablets of 32 mg. (½ grain), 0.1 Gm. (1½ grains) and 0.2 Gm. (3 grains)

WINTHROP-STEARNS INC., New York 18, N.Y., Windsor, Ont.

Mebaral, trademark reg. U. S. & Canada, brand of mephobarbital

The Connecticut State Medical Journal

. . INDEX . .

Volume XVI January-December, 1952

A

Addison, Joseph, On the Prevention of Disease (Blumer) ix 699
Adrenocortical Extract in Pediatrics (Provenzano) ii 89
AMA, Address of the President (Cline) viii 577
AMA, Chicago, June 9-13, 1952 vii 544
AMA Interim Session, L A Calling i 31
American Medical Education Foundation, Contributors to (as of October 2, 1952) xi 876
Anesthesia, Group Practice of (Garofalo, D'Elia, Kazanjian, Trifari and Golia) viii 594
Annual Reports v 367, vi 462
Anuria Due to Acute Renal Insufficiency, Treatment of (Friedberg) vi 397
Are Veterans People? (Warren) iii 171
Arteriosclerosis, Critique of Current Theories on the Pathogenesis (Hatch) xii 887

B

Bioelectric Correlates of Emotional States (Ravitz) vii 499
Blue Cross Coverage and Hospital Charges, A Study of ii 109
Bodine, Address of Alfred V., President, Conn. Manufacturers Association viii 599
Bone Saw and Drill Table (Goffe) iii 193

C

Cancer, Program of Connecticut Conference iii 188
Cervix, Carcinoma of the, Surgical Methods in the Treatment of (Parsons) iii 155
Cervix, Unsuspected Carcinoma of, In Office Practice, Detection of Clinically, by Vaginal Smear (Wright and Bristoll) iii 162
Charter and By-Laws, Connecticut State Medical Society ii 140
Clinical Congress Advance Program—27th ix 665
Clinical Congress Program, 27th viii 603
Cogswell, Dr. Mason Fitch (Brackett) xii 934
Congestive Failure, A Note on the Management of (Eskwith) vii 527
Connecticut Medical Service vi 444
Convulsive Seizures by Endocrine Therapy, Control of (Moore) ix 679
Cortisone, Premedication of, On the Healing of Wounds in an Infant, Effect of (Rubin and Lischner) ix 682
County Association Meetings, Semi-Annual ix 690

D

Deafness in Children, Conduction (MacCready) iv 252
Defense Civil, Physician's Responsibility in (Wilson) i 3
Accuracy of Certain Chemical Determination in Connecticut Laboratories, The Third Survey (Snavely, Golden and Cooper) xii 894
Diabeteic Menu (Greenhouse) x 736
Diarrhea in Infancy (Stevenson) ix 671
Doctors and Lawyers in Court (Cohen) x 741
Doctor's Office i 50, ii 114, iii 192, iv 293, v 361, vii 529, viii 652, ix 703, x 786, xi 856, xii 925
Dollar, Harnessing the Vanishing (Fenn) xii 908
Doctor's Own Mental Health (Rademacher) ix 689
Doctors' Draft, Statement of the Present Situation as Regards the (Harvey) xii 914
Duodenum, Lesion In and About the Second Partition of (Jaffe) xii 923

E

Editorials:
Alcoholic Patients in General Hospitals iii 181
Anestheisiolgy, A Challenge x 753
Are Veterans People iii 180
Art Exhibit iv 274
Arthritis and Rheumatism Foundation, Connecticut Chapter ii 99
Bertner Foundation Award 1952 (Posthumous) to George Milton Smith vii 526
Blake, Francis Gilman iii 182
Blue Cross, Blue Shield and the Hospital vii 426
Blue Cross Rates and Stabilization ix 836
Cancer Control Month iv 272
Cash Sickness Benefits for Two out of Three Connecticut Workers x 753
Catastrophic Illness Insurance for Members i 20
Children, The World's xi 836
Citizens and Doctors ix 692
Cline, Dr. John W. viii 606
Clinical Case Report x 751
Clinical Congress—1952 viii 610
Clinical Congress, Our ix 693
Congress, A Successful x 754
Connecticut First xi 837
CMS for Physicians ii 98
CMS Plan for Inhospital Medical Care vi 427
Connecticut Story xi 836
County Medical Society iii 181

Editorials:
County P.R. vii 525
Deaths, Accidental, in Connecticut in 1951 v 332
Delegates, House of xii 918
Diabetes Week xi 836
Fairfield County Activates PR Program vi 427
Foods, Drugs, Cosmetics and Devices, Committee on iii 181
For Your Information x 750
Gaylord Farm v 330
Grievance Committees v 331
Hartford Circus Fire: Lawyers and Doctors viii 610
Health-Needs Commission iii 179
Hospital Library x 752
Hospital-Physician Relationship vii 523
Hospital Problems and Doctors x 750
Hypochondriacs' Heaven vi 428
Immobilization, Ill Effects of iv 274
Insurance, Group Catastrophic Illness iv 272
It Can Be Done i 18
Lincoln, Case of Dr. v 331
Lippard, Dean Vernon W. viii 606
Maryland Publishes State Journal v 333
Medical Education and Medical Practice iii 178
Medical Education in the Present Emergency ii 99
Medical Education Study Commission ii 98
Mental Diseases, Problem in vii 524
National Fund viii 610
National Health Service, More About the iv 275
New England Health Institute vi 427
Palsy, Cerebral, in Connecticut v 331
Participating Physicians in CMS xii 919
Pharmacy, 100 Years of vi 427
Pioneers v 330
Pledge and Performance xii 917
Post Doctorate Education ix 691
Professional Relationships i 19
Prognosis, Limitations of vii 524
Psychiatry in General Hospitals i 18
Psychosomatic Medicine iii 182
Red Cross iii 180
Salter, William T., Dr. ix 692
Shangri-La, Lesson of xii 919
Smith, George M. Book Fund xii 918
Socialism by Treaty x 752
Society Loses Oldest Living President i 19
Society, It Is Too Easy to be a Member of a Medical xii 918
Specialism and the Intern Year xi 835
State Medical Journal, Your i 20
Student American Medical Association, Journal of the iii 179
Student American Medical Association vii 525
Surgical and Medical Expense Protection—Some Figures ix 691
Texas, Salute to xi 837
Tinted Optical Glasses x 751
Trinity's New Library xii 918
Tuberculosis in Connecticut x 753
Tuberculosis, New Drugs for viii 608
United Profession iv 273
Vote, About, Something to iv 275
West, Olin—Physician, Statesman, Friend viii 611
Where We Live vii 526
Education Foundation, American Medical, Contributors to the vii 536
Education, Medical, in the Present Emergency (Harvey) ii 73
Employment, Fulltime, of Physicians in Connecticut (Barker) iii 182
Endometriosis and Hormonal Treatment With Testosterone, Early Recognition of (Freiheit) ix 674
Eye Emergencies and the General Practitioner (Fasanella) x 755

F

Fee Tables in Medical Service Insurance, The Structure of (Horton) iv 260
Femoral Shaft, Nailing of the, Intramedullary (Shuktin) vi 430
From Our Exchanges i 52, ii 125, iii 204, iv 295, v 356, vii 560, viii 632, ix 712, x 790, xi 864, xii 950

G

Gaylord Farm Association (Lyman) v 311
Gaylord Farm Sanatorium, Personality of (Harvey) v 327
Grafts, Cancellous, Bone. In Fresh Fractures Coming to Open Reduction (Pike and Larrabee) vii 494

H

Hartford Medicine, Heritage of (Weld) iv 241
Health of the World's Children (Eliot) xi 829
Health Program; National, Statements by National and Congressional Candidates x 767
Hepatitis, Infectious, In Pregnancy (Taylor) viii 587
Heritage, Our Fading (Thompson) vii 518
Hernia Problem in Children (Bonner, Jr.) iii 160
Hernias, Abdominal, Recurrent Umbilical and Low Midline, In Adipose Women (Larkin) i 9
Hip Joint, Osteochondromatosis of the (Dalmain) iv 258
Historian's Note Book i 29, ii 108, v 344, vii 540, ix 699, x 765, xii 934
Hospitals and the Practice of Medicine From the Viewpoint of the Hospital Trustee vi 413
Hydrazine Drugs (Morriss) v 334
Hypersplenism in Pregnancy (Krochmal and Caplan) iv 248

I

Industrial Medicine as a Legitimate Field for the General Practitioner (Kilgus, Jr.) iv 278
Industrial Physician, Responsibility of the, Standing Orders (Lieben) ix 683
Influenza Virus Vaccination in Industry, Value of (Yeager) i 7
Inoculation for Small-Pox in Colonial New England, A Note on (Brackett) vii 540
Insecticides, Medical Importance of Organic Phosphorus (Lieben) vi 407
Insurance, Medical Care, Professional Relations in (Danaher) ii 96
Iron Metabolism in Hemosiderosis and Hemochromatosis (Rankin) i 21

K

Kipling, The Medicine of Rudyard (Blumer) x 765

L

Larynx, Cancer of the, In General Practice (Malkin and Kirchner) xi 816
Letters to the Editor i 64, ii 114, vi 469, viii 654, ix 700, xi 861
Lippard, M.D., Remarks of Vernon W. xii 921
Lodge, Governor John, Remarks of, At 160th Annual Meeting vii 491
Lupus Erythematosus In a Thirteen Year Old White Male, Acute Disseminated (Bentas, Spencer and Penner) vii 513

M

Maternal Mortality and Morbidity in Connecticut, A Five Year Study—1946-1950 Inclusive (Johnson) xi 809
Medical Examination in School Health Service (Van Kleck) xi 850
Medical Examinations, Pre-Employment, To Select—Not Reject (Foker) xi 822
Medication, Subcutaneous, The Story of (Blumer) i 29
Middle Man in Physician-Hospital Relations (McKittrick) iv 263
Military Affairs i 41, iii 202, iv 294, v 353, vi 461, vii 558, viii 630, ix 709, x 788, xi 860, xii 941

N

Narcotics Problem in Connecticut (Griffin) ii 91
Narcotics Problem in Connecticut II (Griffin) vi 408
New Books in Review i 68, ii 136, iii 220, iv 306, v 390, vi 485, vii 572, viii 658, ix 722, xi 874, xii 964
News From County Associations i 66, ii 134, iii 216, iv 304, v 384, vi 480, vii 568, viii 656, ix 718, x 805, xi 880, xii 960
News From Washington i 45, ii 120, iii 196, iv 288, v 349, vi 458, vii 550, viii 626, ix 706, x 781, xi 858, xii 943
News From Yale University School of Medicine ii 136, iii 220, iv 304, v 388, vi 484, vii 570, ix 722, xii 966
Nocturia in, Malnutrition (Vernon) x 739

O

Obituaries:
Arnold, Harold Sears iii 206
Cook, Robert J. iii 207
Henderson, Alfred Collard v 360
Keating, John J. v 360
Roche, Thomas J. viii 634
Sellew, Sr., Robert Corwin ii 128
Obstetrics, Newer Trends in (Schmitz) vi 416
Our Neighbors ii 134, iii 216, iv 304, vi 480, viii 654, xi 880, xii 960

P

Pancreas, Internal Drainage in the Treatment of Pseudocysts (Tarabishy) xii 903
Pericarditis, Nonspecific Benign (Prestley) ii 100
Pleurisy, Tuberculosis, With Effusion: Its Significance and Management (LeRoyer) iii 184
Poliomyelitis Policy Committee of the Fairfield County Medical Association, Report of the (Stringfield) vi 429
Political Medicine (Patterson) i 15
President's Page i 25, ii 103, iii 187, iv 281, v 339, vi 434, vii 530, viii 616, ix 696, x 759, xi 842, xii 926
Preventive Aspects of Chronic Disease, A Public Responsibility ii 112
Programs, Annual County Association Meetings iii 189, iv 269
Program, 160th Annual Meeting iv 229
Program, 160th Annual Meeting State Medical Society iii 174
Programs, Semi-Annual County Association Meetings x 749
Progress in Clinical Medicine i 21, ii 100, iii 184, iv 278, v 334, vi 430, vii 527, viii 612, x 755, xi 838, xii 923
Public Relations i 48, ii 115, iii 194, iv 285, v 346, vi 454, vii 555, viii 619, ix 702, x 778, xi 854, xii 947

R

Relations of Physicians and Hospitals i 35
Rheumatic Fever, Prophylaxis of (Levey) xii 899
Role, Changing, of the Physician in His Relationship With the Hospital of the Future (Gunderson) x 727
Rosacea With Complications: Case Report (Kalman) vii 517
Roster, Woman's Auxiliary Members viii 635

S

Secretary's Office i 26, ii 104, iii 190, iv 282, v 340, vi 435, vii 531, viii 617, ix 697, x 760, xi 843, xii 927
Special Notices i 62, ii 130, iii 212, iv 300, v 361, vi 474, vii 566, viii 650, ix 717, x 800, xi 869, xii 956
State Department of Health ii 123
Sterility Problems, Newer Aspects of Fertility and (Hepburn) viii 612
Surgery In a Small Hospital, Twenty-Five Years of (Phillips) xi 826
Surgery, Residency Training in, Future of (Lindskog) vi 410

T

Telangiectasia, Hereditary, Hemorrhagic, With Pulmonary Arteriovenous Aneurysm (Kushlan) vii 505
Telepaque, An Evaluation of, A New Cholecystographic Medium (Lowman and Stanley) viii 591
Thrombosis, Retinal Venous, New Theories of (Birge) viii 582
Thyrocardiac Disease, Present Status of Diagnosis and Treatment of (Friedberg) iii 164
Torula Infection of the Central Nervous System (Wasserman) ii 85
Toxoplasmosis: Congenital, Case Report (Barnett with Lebhar and Longworth) x 731
Tuberculosis—1952 (Emerson) v 323
Tuberculosis Control in Connecticut (Phelps and Edson) v 320
Tuberculosis, Pulmonary, Some Observations on the, Surgical Treatment of (Kelley) v 318
Tuberculosis, Quiescent Pulmonary, Some Factors Influencing Reinfection in or Reactivation of, (Blumer) v 326

Tuberculosis Association, Voluntary, The Role of the (Baird) v 316
Tularemia in Connecticut (Woodworth) xi 838

U

Ulcer, Duodenal, Is, Hereditary (McCormack and Kearney) ii 82
Urea-Splitting Bacteria in Urolithiasis: The Role of (Collier, Reich and King) iv 257

V

Veterans, Connecticut Plan for Medical Care xi 845
Voluntary Health Agencies, Purposes and Functions of (Ryan) iv 276

W

Woman's Auxiliary i 56, ii 129, iii 209, iv 298, v 383, vi 470, vii 564, ix 714, xi 866, xii 952

. . INDEX . .

Volume XVI — January-December, 1952

B

Baird, Mabel
Tuberculosis Association, Voluntary, The Role of the v 316
Barker, Creighton
Employment, Fulltime, of Physicians in Connecticut iii 182
Barnett, Roy N. (with Lebhar and Longworth)
Toxoplasmosis: Congenital, Case Report x 731
Bentas, Nicholas (with Spencer and Penner)
Lupus Erythematosus in a Thirteen Year Old White Male, Acute Disseminated vii 513
Birge, Henry L.
Thrombosis, Retinal Venous, New Theories of viii 582
Blumer, George
Medication, Subcutaneous, The Story of i 29
Tuberculosis, Quiescent Pulmonary, Some Factors Influencing Reinfection in or Reactivation of v 326
Addison, Joseph, On the Prevention of Disease ix 699
Kipling, The Medicine of Rudyard x 765
Bonner, Jr., Robert A.
Hernia Problem in Children iii 160
Brackett, Arthur S.
Inoculation for Small-Pox in Colonial New England, A Note on vii 540
Cogswell, Dr. Mason Fitch xii 934
Bristoll, Donald A. (with Wright)
Cervix, Unsuspected Carcinoma of, In Office Practice, Detection of Clinically, By Vaginal Smear iii 162

C

Caplan, Max (with Krochmal)
Hypersplenism in Pregnancy iv 248
Cline, John W.
AMA, Address of the President viii 577
Cohen, Louis H.
Doctors and Lawyers in Court x 741
Collier, Fred C. (with Reich and King)
Urea-splitting Bacteria in Urolithiasis: The Role of iv 257
Cooper, Alan B. (with Snavely and Golden)
Determinations in Connecticut Laboratories, Accuracy of Certain Chemical—The Third Survey xii 894

D

Dalmain, Walter A.
Hip Joint, Osteochondromatosis of the iv 258
Danaher, Thomas J.
Insurance, Medical Care, Professional Relations in ii 96
D'Elia, Pierino F. (with Garofalo, Kazanjian, Trifari, and Golia)
Anesthesia, Group Practice of viii 594

E

Edson, Reginald C.
Tuberculosis Control in Connecticut v 320
Eliot, Martha M.
Health of the World's Children xi 829
Emerson, Kendall
Tuberculosis—1952 v 323
Eskwith, Irwin S.
Congestive Failure, A Note on the Management of vii 527

F

Fasanella, R. M.
Eye Emergencies and the General Practitioner x 755
Fenn, Francis T.
Dollar, Harnessing the Vanishing xii 908
Foker, Leslie W.
Medical Examinations, Pre-Employment, To Select—Not Reject xi 822
Freiheit, John M.
Endometriosis and Hormonal Treatment With Testosterone, Early Recognition of ix 674
Friedberg, Charles K.
Thyrocardiac Disease, Present Status of Diagnosis and Treatment of iii 164
Anuria Due to Acute Renal Insufficiency, Treatment of vi 397

G

Garofalo, Mario L. (with D'Elia, Kazanjian, Trifari, and Golia)
Anesthesia, Group Practice of viii 594

Goffe, Charles Weer
Bone Saw and Drill Table iii 193
Golden, W. R. C. (with Snavely and Cooper)
Determinations in Connecticut Laboratories, Accuracy of Certain Chemical—The Third Survey xii 894
Golia, Ulysses V. (with Garofalo, D'Elia, Kazanjian, and Trifari)
Anesthesia, Group Practice of viii 594
Greenhouse, Barnett
Diabetic Menu x 736
Griffin, Daniel P.
Narcotics Problem in Connecticut ii 91
Narcotics Problem in Connecticut II vi 408
Gunderson, Gunnar
Role of the, Changing, Physician in His Relationship With the Hospital of the Future x 727

H

Harvey, Samuel C.
Education, Medical, in the Present Emergency ii 73
Gaylord Farm Sanatorium, Personality of v 327
Doctors' Draft, Statement of the Present Situation as Regard the, xii 914
Hatch, Frederick T.
Arteriosclerosis, Critique of Current Theories on the Pathogenesis xii 887
Hepburn, Robert H.
Sterility Problems, Newer Aspects of Fertility and viii 612
Horton, Willam H.
Fee Tables in Medical Service Insurance, The Structure of iv 260

J

Jaffe, N. B.
Duodenum, Lesion In and About the Second Partition of xii 923
Johnson, Carl E.
Maternal Mortality and Morbidity in Connecticut, A Five Year Study—1946-1950 Inclusive xi 809

K

Kalman, Eugene F.
Rosacea With Complications: Case Report vii 517
Kazanjian, Norton A. (with Garofalo, D'Elia, Trifari and Golia)
Anesthesia, Group Practice of viii 594
Kearney, Maurice W. (with McCormack)
Ulcer, Duodenal, Is, Hereditary? ii 82
Kelley, Winfield O.
Tuberculosis, Pulmonary, Some Observations on the, Surgical Treatment of v 318
Kilgus, Jr., John F.
Industrial Medicine as a Legitimate Field for the General Practitioner iv 278
King, John W. (with Collier and Reich)
Urea-splitting Bacteria in Urolithiasis: The Role of iv 257
Kirchner, John A. (with Malkin)
Larynx, Cancer of the, In General Practice xi 816
Krochmal, Harry (with Caplan)
Hypersplenism in Pregnancy iv 248
Kushlan, Samuel D.
Telangiectasia, Hereditary, Hemorrhagic, With Pulmonary Arteriovenous Aneurysm vii 505

L

Larkin, Charles L.
Hernias, Abdominal, Recurrent Umbilical and Low Midline, in Adipose Women i 9
Larrabee, J. Whitfield (with Pike)
Grafts, Cancellous, Bone, In Fresh Fractures Coming to Open Reduction vii 494
Lebhar, Neil F. (with Barnett and Longworth)
Toxoplasmosis: Congenital, Case Report x 731
LeRoyer, C. P.
Pleurisy, Tuberculous, With Effusion: Its Significance and Management iii 184
Levy, Daniel F.
Rheumatic Fever, Prophylaxis of xii 899
Lieben, Jan
Insecticides, Medical Importance of Organic Phosphorus vi 407
Industrial Physician, Responsibility of the, Standing Orders ix 683
Lindskog, Gustaf E.
Surgery, Residency Training in, Future of vi 410
Lischner, Moses D. (with Rubin)
Cortisone, Premedication of, On the Healing of Wounds in An Infant, Effect of ix 682
Longworth, Edmund F. (with Barnett and Lebhar)
Toxoplasmosis: Congenital, Case Report x 731
Lowman, Robert M. (with Stanley)
Telepaque, An Evaluation of, A New Cholecystographic Medium viii 591
Lyman, David R.
Gaylord Farm Association v 311

M

Malkin, Jocelyn S. (with Kirchner)
Larynx, Cancer of the, In General Practice xi 816
MacCready, Paul B.
Deafness in Children, Conduction iv 252
McCormack, Christopher J. (with Kearney)
Ulcer, Duodenal, Is, Hereditary? ii 82
McKittrick, Leland S.
Middle Man in Physician-Hospital Relations iv 263
Moore, Maurice R.
Convulsive Seizures by Endocrine Therapy, Control of ix 679
Morriss, W. Haviland
Hydrazine Drugs v 334

P

Parson, Langdon
Cervix, Carcinoma of the, Surgical Methods in the Treatment of iii 155
Patterson, James T., Congressman
Political Medicine i 15
Penner, Sidney L. (with Bentas and Spencer)
Lupus Erythematosus in a Thirteen Year Old White Male, Acute Disseminated vii 513

Phelps, Paul S.
Tuberculosis Control in Connecticut v 320
Phillips, Karl T.
Surgery In a Small Hospital, Twenty-Five Years of xi 826
Pike, Maurice M. (with Larrabee)
Grafts, Cancellous, Bone, In Fresh Fractures Coming to Open Reduction vii 494
Prestley, William F.
Pericarditis, Nonspecific Benign ii 100
Provenzano, William
Adrenocortical Extract in Pediatrics ii 89

R

Rademacher, Everett S.
Doctor's Own Mental Health ix 685
Rankin, E. Clair
Iron Metabolism in Hemosiderosis and Hemochromatosis i 21
Ravitz, L. J.
Bioelectric Correlates of Emotional States vii 499
Reich, Alfred (with Collier and King)
Urea-splitting Bacteria in Urolithiasis: The Role of iv 257
Rubin, Albert (with Lischner)
Cortisone, Premedication of, On the Healing of Wounds in An Infant, Effect of ix 682
Ryan, Allan J.
Voluntary Health Agencies, Purposes and Functions of iv 276

S

Schmitz, Herbert E.
Obstetrics, Newer Trends in vi 416
Shutkin, Ned M.
Femoral Shaft, Nailing of the, Intramedullary vi 430
Snavely, J. G. (with Golden and Cooper)
Determinations in Connecticut Laboratories, Accuracy of Certain Chemical—The Third Survey xii 894
Spencer, Jean A. (with Bentas and Penner)
Lupus Erythematosus in a Thirteen Year Old White Male, Acute Disseminated vii 513
Stanley, Howard W. (with Lowman)
Telepaque, An Evaluation of, A New Cholecystographic Medium viii 591
Stevenson, Stuart Shelton
Diarrhea In Infancy ix 671
Stringfield, Oliver L.
Poliomyelitis Policy Committee of the Fairfield County Medical Association, Report of the vi 429

T

Tarabishy, Said H.
Pancreas, Internal Drainage in the Treatment of Pseudocysts xii 903
Taylor, Hoyt C.
Hepatitis, Infectious, In Pregnancy viii 587
Thompson, Hartwell G.
Heritage, Our Fading vii 518
Trifari, Leopold M. (with Garofalo, D'Elia, Kazanjian, and Golia)
Anesthesia, Group Practice of viii 594

V

Van Kleck, Edwin R.
Medical Examination in School Health Service xi 850
Vernon, Sidney
Nocturia in, Malnutrition x 739

W

Warren, Richard
Are Veterans People? iii 171
Wasserman, Edward
Torula Infection of the Central Nervous System ii 85
Weld, Stanley B.
Hartford Medicine, Heritage of iv 241
Wilson, William L., Colonel
Defense, Civil, Physician's Responsibility in i 3
Woodworth, John A.
Tularemia in Connecticut xi 838
Wright, Ralph C. (with Bristoll)
Cervix, Unsuspected Carcinoma of, In Office Practice, Detection of Clinically, By Vaginal Smear iii 162

Y

Yeager, C. F.
Influenza, Virus Vaccination in Industry, Value of i 7

1st Lieutenant Lloyd L. Burke U.S. Army Medal of Honor





THE RED KOREAN strongpoint had stalled our attack; Lieutenant Burke saw that a breakthrough must be made. Rallying 35 men, he crept close to the enemy bunkers. He laid down a grenade barrage. Then he ran forward to an exposed knoll and opened a one-man pitched battle. He turned a light machine gun into the Red position. He caught live enemy grenades in mid-air and threw them back. Once he killed three men with his pistol. Before sunset Lieutenant Burke and 35 men had defeated 300. The lieutenant says:

"Every day, men who fought in Korea are coming home. They're finding jobs—partly because they and you and I own nearly 50 billion dollars' worth of U.S. Defense Bonds. For Bond savings—which protect our families financially—are also building a great backlog of *national* prosperity. Reason enough for investing in Bonds—don't you agree?"

★ ★ ★

Now E Bonds earn more! 1) All Series E Bonds bought after May 1, 1952 average 3% interest, compounded semiannually! Interest now starts after 6 months and is higher in the early years. 2) *All maturing E Bonds* automatically go on earning *after maturity*—and at the new higher interest! Today, start investing in better-paying Series E Bonds through the Payroll Savings Plan where you work! Or inquire at any Federal Reserve Bank or Branch about the Treasury's brand-new Bonds, Series H, J, and K.

Peace is for the strong! For peace and prosperity save with U.S. Defense Bonds!

The U.S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

U. C. MEDICAL LIBRARY
AUG 20 1952
San Francisco, 22

Connecticut State Medical Society

ROSTER OF MEMBERS

ALPHABETICAL ROLL OF MEMBERS

July 31, 1952

Suppliment to
CONNECTICUT STATE MEDICAL JOURNAL
Volume XVI, Number 8
August, 1952

ROSTER OF MEMBERS, 1952

CONNECTICUT STATE MEDICAL SOCIETY
OFFICERS

President: Edward J. Whalen, Hartford
President-elect: George H. Gildersleeve, Norwich
First Vice-President: Thacher W. Worthen, Hartford
Second Vice-President: Carl C. Harvey, Middletown
Executive Secretary: Creighton Barker, New Haven
Treasurer: Frank H. Couch, Cromwell
Editor of the Journal: Stanley B. Weld, Hartford

Fairfield County Association

President: Isaac L. Harshbarger, 144 Golden Hill St., Bridgeport
Vice-President: Charles S. Knapp, 18 Field Point Rd., Greenwich
Secretary: Edwin R. Connors, 416 Boston Ave., Bridgeport
Treasurer: Clifton C. Taylor, 881 Lafayette St., Bridgeport
Councilor: C. Louis Fincke, 1 Atlantic St., Stamford
Alternate Councilor: John P. Gens, 64 Wall St., Norwalk

Annual Meeting, Second Tuesday in April, at Bridgeport
Semi-Annual Meeting, First Wednesday in October

BETHEL

1945 Mandl, George 234 Greenwood Ave.
1925 Moore, H. Frank, 4 Grand Ave.
1938 Trimpert, Albert Joseph, 155 Greenwood Ave.
1939 Wolfson, Dexter, 58 Greenwood Ave.

BRIDGEPORT

1933 Adzima, Joseph Matthew, 409 Noble Ave.
1941 Akerson, Irving B., Bridgeport Hospital
1932 Alpert, Max, 881 Lafayette
1944 Amarant, Leo, 881 Lafayette
1935 Antell, Maxwell Joseph, 800 Clinton Ave.
1920 Apsel, Abraham, 1620 Fairfield Ave.
1942 Apuzzo, Anthony Albert, 17 Villa Ave.
1948 Aube, Louis Armond, 2708 Main
1928 Backer, Marcus, 881 Lafayette
1938 Bakunin, Maurice Irving, 881 Lafayette
1916 Banks, Daniel Tony, 385 Barnum Ave.
1951 Baum, Seymour James, 928 Lafayette
1913 Beaudry, Joseph Horace, 109 Rowsley
1941 Beck, Sidney Henry, 881 Lafayette
1941 Bellew, Raymond F., 905 Clinton Ave.
1913 Bernstein, Abraham, 881 Lafayette
1946 Birney, Thomas Peter, 1984 Park Ave.
1949 Blaney, Cyril Chandler, 3203 Main
1935 Bogin, Maxwell, 144 Golden Hill
1921 Booe, J. Grady, 144 Golden Hill
1947 Braun, Rudolf, 525 Clinton Ave.
1941 Brier, Hyman David, 2583 Main
1927 Brodsky, Michael Emanuel, 881 Lafayette
1940 Brooks, Paul Lester, 1260 East Main
1939 Buckhout, George Atherton, 144 Golden Hill
1938 Buckley, John William, 2080 North Ave.
1945 Buda, Gaza Edward, 1831 Barnum Ave.
1940 Burns, Bernard John, 1101 East Main
1943 Cacace, Vincent Anthony, 1802 Park Ave.
1919 Calvin, Claudius Virgil, 144 Golden Hill
1947 Camarda, Anthony L., 1026 Park Ave.
1945 Capobianco, Arthur Paul, 932 East Main
1946 Cardone, Michael James, 2989 Main
1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.
1947 Caserta, Silvio Joseph, 880 North Ave.
1940 Castaldo, Louis F., 10 Washington Ave.
1947 Cavaliere, Vincent J., 634 Washington Ave.
1920 Cheney, Maurice Lionel, 144 Golden Hill
1951 Chick, Forris Beechan, R. F. D. No. 1, Box 400
1949 Chiota, Joseph A., 562 Boston Ave.
1941 Clark, William Thompson, 881 Lafayette
1924 Conklin, Cornelius Stephen, 468 Clinton Ave.
1936 Connors, Edwin Robert, 416 Boston Ave.
1935 Creaturo, Nicholas, Edward, 1286 East Main
1913 Curley, William Henry, 881 Lafayette
1947 Curley, William Henry, Jr., 881 Lafayette
1908 Curran, Philip John, 370 Brooklawn Ave.
1950 Dean, Michael Augustine, 881 Lafayette
1946 Delevett, Allen Fitzhugh, 144 Golden Hill
1920 DeLuca, Horatio Roger, 881 Lafayette
1950 DeLuca, Joseph Vincent, 881 Lafayette
1935 Del Vecchio, Leonard Frederick, 60 Crown
1947 Deren, M. David, 1026 Park Ave.
1921 DeWitt, Edward Nicholas, 881 Lafayette
1945 Donnelly, William Augustus, 2112 North Ave.
1941 Duzmati, Paul Peter, 1904 Boston Ave.
1941 Eddy, Maxon Hunter, 144 Golden Hill
1949 Edwards, Larry Edwin, 968 East Main
1937 Eimas, Aaron, 881 Lafayette
1948 Elliott, Frank George, Jr., 1741 Stratford Ave.
1946 Eskwith, Irwin Stanley, 881 Lafayette
1939 Esposito, Joseph John, 144 Golden Hill
1951 Ferrucci, James Christopher, 192 Farmington Ave.
1938 Findorak, Francis George, 923 East Main
1943 Fink, Lisbeth, 3166 Main
1913 Finkelstone, Benjamin Brooks, 1854 North Ave.
1951 Fleisher, Philip, 1026 Park Ave.
1938 Foley, Francis Xavier, 3100 Main
1916 Gade, Carl Johannes, 144 Golden Hill
1939 Gaffney, Charles Bernard, 610 Brooklawn Ave.
1929 Garbelnick, David Abraham, 1102 East Main
1907 Gardner, Charles Wesley, 144 Golden Hill
1950 Gardner, Sidney Martin, 545 Maplewood Ave.
1916 Garlick, George Burroughs, 144 Golden Hill
1951 Geanuracos, George James, 932 East Main
1940 Geer, William Allyn, 881 Lafayette
1916 Gilday, James Lowry, 819 State
1927 Gildea, Mark Andrew, 881 Lafayette
1951 Ginzler, Arthur M., 2820 Main
1948 Glass, William I., 1026 Park Ave.
1895 Gold, James Douglas, 839 Myrtle Ave.
1950 Goodrich, Albert, 881 Lafayette
1946 Goodrich, William J., 3120 Fairfield Ave.
1950 Gorman, Vincent Augustine, 928 Lafayette
1927 Greenspun, David Stoven, 144 Golden Hill

1916 Griffin, Daniel Patrick, 1278 East Main
1923 Griswold, Arthur Sheldon, 144 Golden Hill
1928 Griswold, Crawford, 144 Golden Hill
1920 Groark, Owen James, 881 Lafayette
1943 Grossman, John Henry, 144 Golden Hill
1941 Gulash, John Robert, 562 Boston Ave.
1949 Guttman, Tibor, 1549 Fairfield Ave.
1913 Hale, Fraray, 144 Golden Hill
1947 Hanley, James Leo, Jr., 928 Lafayette
1939 Hardenbergh, Daniel Bailey, 144 Golden Hill
1928 Harshbarger, Isaac Long, 144 Golden Hill
1946 Hart, Benjamin Ide, 453 State
1948 Harwood, Paul Henry, Jr., 144 Golden Hill
1920 Havey, Leroy Austin, 144 Golden Hill
1938 Hennessey, Joseph Gerard, 482 Brewster
1930 Hooper, G. Herbert, 393 Laurel Ave.
1933 Horn, Benjamin, 754 Clinton Ave.
1946 Horowitz, Isaac, 928 Lafayette
1920 Howard, Joseph Henry, 144 Golden Hill
1948 Ives, Eli Bolton, 144 Golden Hill
1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.
1943 Jones, Elwood King, 881 Lafayette
1932 Kalman, Eugene, 622 Clinton Ave.
1942 Kaplan, Leon, 881 Lafayette
1948 Kaufman, Maurice, 401 Grovers Ave.
1941 Kaufman, William, 541 Brooklawn Ave.
1927 Keegan, Daniel Francis, 144 Golden Hill
1948 Kenigsberg, Nathaniel, 10 Washington Ave.
1946 Kinder, Frederick Stephen, 1026 Park Ave.
1946 Kleinman, Harold Louis, 2051 North Ave.
1924 Kneale, Halford Benson, 144 Golden Hill
1948 Kogut, Henry Vincent, 1026 Park Ave.
1924 Kornblut, Alfred, 1539 Fairfield Ave.
1943 Landecker, Norbert, 2895 Main
1926 Laszlo, Andreas, 881 Lafayette
1940 Lengyel, Paul, 500 Clinton Ave.
1943 Lesko, Joseph Michael, 144 Golden Hill
1925 Levenson, Albert, 881 Lafayette
1948 Levinsky, Aaron, 113 Atwater
1933 Levinsky, Maurice, 480 Noble Ave.
1927 Levy, Maurice Noel, 480 Clinton Ave.
1942 Lieberthal, Milton Morton, 881 Lafayette
1931 Lockhart, R. Harold, 144 Golden Hill
1942 Lopatin, Colman, 965 Fairfield Ave.
1948 Luciano, Michael Charles, 2089 North Ave.
1948 Luria, Sydney, 915 North Ave.
1946 Lyddy, John Roger, 446 Stratford Ave.
1937 Lynch, Hubbard, 881 Lafayette
1887 Lynch, John Charles, 826 Myrtle Ave.
1904 Lynch, Robert Joseph, 144 Golden Hill
1947 Lynch, Vincent Aloysius, 928 Lafayette
1944 Lyon, Grover Arthur, 2009 North Ave.
1948 Mack, Arthur Gerard, 881 Lafayette
1949 Manjoney, Vincent August, 2464 East Main
1932 Marglis, Ben, 171 Harrison
1949 Markley, Ludwig Louis, 657 Clinton Ave.
1951 Martelon, George Fred, 1285 Boston Ave.
1941 Martin, Raymond Alfred, 144 Golden Hill
1942 Massey, Daniel M., Bridgeport Hospital
1922 Maxwell, John Alphonsus, 254 East Main
1950 McCreery, Edward Prince, Jr., 649 Clinton Ave.
1945 McGovern, Edward F., 881 Lafayette
1938 McLean, Thomas Smith, Jr., 144 Golden Hill
1947 McNamara, Alexander P., 3354 Main
1913 McQueeney, Andrew Michael, 1315 Noble Ave.
1952 Meltzer, Saul B., 881 Lafayette
1946 Meshken, Jacob, 928 Lafayette
1931 Meyer, Fritz Martin, 144 Golden Hill
1892 Miles, Henry Shillingford, 144 Golden Hill
1947 Molnar, George J., 1026 Park Ave.
1940 Monahan, David Tuite, 144 Golden Hill
1932 Mooney, Sydney, 881 Lafayette
1945 Morgan, Kenneth Remsen, 144 Golden Hill
1946 Morris, Felix R., 953 East Main
1950 Murdock, Charles Lewis, R. F. D. No. 1, Box 400
1936 Murray, William Joseph, 144 Golden Hill
1948 Nagourney, David, 1756 East Main
1901 Nettleton, Irving La Field, 775 Washington Ave.
1919 Neumann, Harry Aaron, 965 Fairfield Ave.
1948 Newman, Abbott A., 951 Park Ave.
1937 Newton, Louis, 881 Lafayette
1925 Nichols, Charles Williams, 1221 Stratford Ave.
1936 Nolan, John Francis, 1260 East Main
1947 Northman, Frank Fred, 1884 Park Ave.
1926 Oberg, Frank Thorwald, 1875 Park Ave.
1952 O'Brien, James Miles, 735 Clinton Ave.
1943 O'Neil, John Joseph, 1468 Stratford Ave.
1944 Oros, Louis Michael, 555 Clinton Ave.
1944 Oster, Kurt A., 881 Lafayette
1947 Owens, Andrew Paul, 144 Golden Hill
1950 Paget, John Francis, 144 Golden Hill
1940 Panettieri, Andrew Joseph, 144 Golden Hill
1942 Parker, Ralph Layton, 881 Lafayette
1921 Parmelee, Berkley Melvin, 144 Golden Hill
1937 Pascal, Thomas J., 1560 Noble Ave.
1944 Pasquariello, Domenico William, 2969 Main
1946 Pellens, Mildred, 1278 East Main
1951 Pickren, Thomas Ryer, 923 East Main
1930 Pileggi, Peter, 743 Washington Ave.
1932 Pitock, Morris Philip, 881 Lafayette
1935 Plukas, Joseph Martin, 339 South Ave.
1942 Popkin, Michael Sherman, 1671 Noble Ave.
1941 Pratt, George Kenneth, 881 Lafayette
1933 Quatrano, Joseph Charles, 893 Clinton Ave.
1916 Quinn, John Francis, 144 Golden Hill
1941 Quinn, Katherine Sarah, 2970 North Main
1951 Rayl, Donald Frederick, 144 Golden Hill
1916 Reich, Upton Sharetts, 2095 Main
1940 Reiter, Benjamin Reynolds, 144 Golden Hill
1942 Resnik, Harry, 881 Lafayette
1938 Ribner, Harold, 64 Lyon Ter.
1950 Riccio, Frank Joseph, 923 East Main
1918 Roberts, Edward Russell, 144 Golden Hill
1936 Rockwell, Alice Elizabeth, 2210 Park Ave.
1950 Romaine, Frank Cleeland, 1278 East Main
1944 Rosenberg, Hans August, 1621 East Main
1946 Rosenberg, Saul, 1950 Park Ave.
1946 Rosner, Fred, 2333 North Ave.
1947 Rudnick, Charles J., 42 Yale
1949 Russo, John Rocco, 3296 Main
1948 Russo, Robert Dante, 10 Washington Ave.
1949 Saidel, Joseph W., 2151 Park Ave.
1948 Savin, Sanford, 155 Brooklawn Ave.
1942 Scalzi, Leonard Conrad, 924 Noble Ave.
1946 Schopick, Louis E., 2090 North Ave.
1943 Sciortino, Michael Vincent, 2072 North Ave.
1947 Scully, Michael Richard, 3265 Main
1928 Sekerak, Arthur Joseph, 408 Barnum Ave.
1938 Sekerak, Raymond Andrew, 1400 East Main
1938 Sekerak, Richard John, 938 East Main
1938 Shea, Cornelius Joseph, 1153 Park Ave.
1913 Shea, John, 144 Golden Hill
1946 Sheiman, Milton, 1539 Park Ave.
1946 Sheiman, Samuel Charles, 1539 Park Ave.
1947 Sherman, Benjamin, 175 Brooklawn Ave.
1947 Sherman, Irving J., 1026 Park Ave.
1944 Sholler, Nicholas A., 2148 North Ave.
1939 Simses, John Peter, 144 Golden Hill

1950 Small, Alan Robert, 605 West Taft Ave.
1935 Smith, Joseph Jacob, 800 Stratfield Rd.
1919 Smith, Stanton Reinhart, 144 Golden Hill
1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.
1930 Sollosy, Alexander, 1430 Fairfield Ave.
1951 Spencer, Samuel, 881 Lafayette
1941 Spinelli, Nicholas Victor, 1285 Noble Ave.
1909 Sprague, Charles Harry, 29 Hanover
1949 Staub, Philip Leo, 951 Park Ave.
1946 Stein, Julius Daniel, 951 Park Ave.
1949 Stevens, John Gutehall, 10 Washington Ave.
1935 Strayer, Luther Milton, Jr., 144 Golden Hill
1948 Sulzycki, Marion, Michael, 355 Noble Ave.
1948 Szur, Ralph James, 815 Clinton Ave.
1940 Tarasovic, Thomas Joseph, 49 Dover
1920 Taylor, Clifton Clark, 881 Lafayette
1938 ter Kuile, Roger Couvelle, 881 Lafayette
1950 Terry, Jules Seheggia, Hawthorne Ter., R. F. D. 5
1925 Tolk, Nathan Robert, 558 Clinton Ave.
1920 Tracey, William Wallace, 63 Louisiana Ave.
1942 Trautman, Edwin Frederick, 5367 Main
1929 Turchik, Frank, 1831 Barnum Ave.
1947 Turetsky, Samuel, 2718 Fairfield Ave.
1941 Tutles, Alexander James, Hillside Hospital
1943 Unger, Milton, 1025 Central Ave.
1932 Uvitsky, Irving Harry, 3101 Main
1947 Veneruso, Leonard Charles, 1690 Barnum Ave.
1941 Vioni, R. Edward, 3450 Main
1948 Walzer, Eugene Harold, 10 Washington Ave.
1942 Ward, James P., 881 Lafayette
1903 Warner, George Howell, 144 Golden Hill
1951 Wasserman, Edward, 881 Lafayette
1920 Watts, Joseph Francis, 881 Lafayette
1913 Weadon, W. Lee, 144 Golden Hill
1934 Wehger, Roland Theodore, 144 Golden Hill
1922 Weise, Ellwood Carl, 144 Golden Hill
1948 Weise, Ellwood Carl, Jr., 144 Golden Hill
1947 Yasser, Isidore, 1302 Stratford Ave.
1936 Yeager, C. Frederick, 923 East Main
1935 Zaur, Israel Sidney, 881 Lafayette
1946 Zavadier, Nathan, 68 Ocean Ave.
1947 Zielinski, John Blaise, 562 Boston Ave.
1943 Zsiga, Elmo Douglas, 303 Clinton Ave.

BROOKFIELD CENTER

1948 Ralston, Richard Marion, Whisconier Hill

DANBURY

1929 Amos, Isadore Louis, 323 Main
1929 Booth, John Dibble, 173 Main
1941 Brochu, Eugene Dalva, 229 Main
1902 Bronson, William Thaddeus, 41 West
1947 Burnie, George A., 105 Main
1952 Castro, Roger Perez, 10 Balmforth Ave.
1952 Cherry, Joseph Bentley, 345 Main
1951 Conway, Francis Michael, 116 Main
1942 DeKlyn, Ward B., 177 Main
1928 Deloherty, Cornelius Leo, 65 Main
1935 Driscoll, Jerome James, 345 Main
1937 Eckert, George Robert, 394 Main
1947 Edson, Dean Harding, 75 West
1947 Epstein, Benjamin, 8 Locust Ave.
1931 Gaffney, John James, 215 Main
1931 Genovese, Frank Thomas, 172 White
1938 Genovese, Serafino, 390 Main
1930 Gibson, Donald Farnham, 75 West
1929 Goldys, Frank Max, 209 Main
1947 Gonzalez, Luis D., 27 Osborne
1897 Gordon, William Francis, 26 West
1950 Leone, Frank, 345 Main
1948 McIlroy, Patrick Thomas, Danbury Hospital
1937 Murphy, James Joseph, 147 Main
1951 Murphy, John Christopher, 65 Main
1949 Patterson, Harold Calvin, 8 West
1950 Pfeiffer, Paul Henry, 345 Main
1949 Randolph, Martin Francis, 345 Main
1937 Rogol, Louis, 85 West
1947 Ruiz, Rolando R., 208 Main
1926 Selleck, Nathaniel Benedict, 215 Main
1913 Smith, Arthur Charles, 246 Main
1951 Sokolski, Edward John, 246 Main
1949 Spannaus, Fred C., Jr., 8 Chapel Pl.
1920 Stahl, William Martin, 343 Main
1947 Stahl, William Martin, Jr., 343 Main
1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.
1929 Sunderland, William Alexander, 158 Deer Hill Ave.
1932 Tomaino, Felix Francis, 8 West
1943 Weiner, William, Danbury Hospital
1947 Yoburn, Michael Myer, 65 West

DARIEN

1951 Brown, David Arthur, 160 Post Rd.
1951 Felder, Edward Arnold, 160 Post Rd.
1944 Huntington, Frederic Sargent, Middlesex and Hollow Tree Ridge Rd.
1948 Lane, Warren Zeph, 160 Post Rd.
1952 McDonald, Harold T., 188 Post Rd.
1941 Moore, Gilbert Emerson, 178 Post Rd.
1949 Moulyn, Adrian Cornelius, 160 Post Rd.
1940 Ross, Allan Maxwell, 188 Post Rd.
1950 Schmidt, Werner Felix, 160 Post Rd.
1949 Solway, Sydney Arn, 195 Post Rd.
1938 Van Tassel, Walter, 160 Post Rd.
1946 Voris, Jacques Van Brunt, 22 Old King's Hwy.

FAIRFIELD

1944 Barker, Daniel C., 133 Reef Rd.
1939 Biehn, Donald M. Frick, 47 Parkway
1928 Biehn, Sidney Lister, 133 Reef Rd.
1935 Davis, Thomas Francis, 1583 Post Rd.
1944 Harris, H. Patterson, Jr., 1432 Post Rd.
1947 Joslin, Stuart L., 27 Unquowa Rd.
1948 Kemp, Edward P., 178 Reef Rd.
1949 Kueffner, William Robert, 1275 Post Rd.
1949 Messinger, Henry J., 1597 Post Rd.
1952 Smolen, Elwyn Milton, 1483 Post Rd.

GREENWICH

1940 Adams, Mary, Greenwich Lodge, Apt. 2-I
1935 Amoss, Harold Lindsey, 68 Deerfield Dr.
1939 Anderson, Clifton Winthrop, 116 East Elm
1949 Beaty, John Thurston, Warwick Towers
1952 Bineau, Armand Gerald, 138 Putnam Park
1949 Blossom, Dudley Buck, Greenwich Hospital
1948 Bolton, John Dewey, 29 Hillside Dr.
1950 Bonnett, Dovell Nicholas, 20 Church
1948 Bullen, Benjamin Wells, Jr., 149 Field Point Rd.
1938 Carter Gray, 29 Hillside Dr.
1943 Claps, Ludovic Vincent, 47 Mason
1933 Close, John Frederick, 90 Dayton Ave.
1944 Davol, Rector Thomson, 30 Milbank Ave.
1950 Dean, Peter Michael, Warwick Towers
1950 deCholnoky, Tibor, 40 West Elm
1947 Derkach, Stephen L., 36 Mason

1951 Finn, Frederick Wall, 185 Putnam Park
1951 Freeman, Winifred Kirk, Cedar Hill
1945 Gratz, Charles Murray, 40 West Elm
1940 Grigas, John E., 153 Mason
1942 Halloran, James Vincent, 43 Lexington Ave.
1937 Hawthorne, Julian, Greenwich Towers
1950 Hoffman, John Brooks, 43 Maple Ave.
1949 Hurlbutt, Frank Roy, Jr., 185 Putnam Park
1946 Huss, John Henry, 34 Putnam Park
1949 Huss, Kathryn Smith, 34 Putnam Park
1948 Intriere, Anthony Donald, 18 Field Point Rd.
1927 Knapp, Charles Stanley, 18 Field Point Rd.
1950 Lee, John Frederick, 90 Dayton Ave.
1933 Lockwood, Jane, 271 Lake Ave.
1950 Markley, Henry Eugene, 3 Putnam Park
1949 Mather, Clayton Black, Health Department
1941 Morris, Joyce Stringer, Greenwich Hospital
1944 Morrissett, Leslie Emerson, 261 Lake Ave.
1948 Murray, John Gregg, 29 Hillside Dr.
1924 O'Donnell, Thomas James, 224 Milbank
1939 Reynolds, Whitman Mead, 30 Maher Ave.
1949 Robertson, Gordon Farquhar, 30 Milbank Ave.
1935 Rogers, Robert Page, 111 North
1946 Rourke, Thomas Alfred, 161 Mason
1938 Serrell, Howard P., 43 Maple Ave.
1940 Shaw, Lillian Eloise, 45 Field Point Rd.
1947 Stephens, Duncan C., Ituri Towers
1940 Swarts, William B., Warwick Towers
1937 Thompson, Sidney Attilio, 161 Mason
1940 Tiebout, Harry Morgan, 30 Milbank Ave.
1934 Tinkess, Donald Ewing, Stanwich Rd.
1939 Tunick, George L., 193 Mason
1948 Walker, John Mercer, 40 West Elm
1942 Weber, Frederick Clarence, Jr., 185 Putnam Park
1947 Wright, Harold S., Ituri Towers

Byram

1949 Hardt, George William, 1 North Water

Cos Cob

1950 Amico, Pasquale Joseph, Diamond Hill
1940 Ayres, Payson Bryan, 10 Old Post Rd.
1912 Bergin, Thomas Joseph, 2 Mead Ave.
1940 Bria, William Francis, 525 East Putnam Ave.
1940 Howard, Leonard Arnold, 3 Strickland Rd.
1950 Losito, Amedeo Joseph, 19 Salem

Old Greenwich

1948 Atkins, Richard Travis, 312 Sound Beach Ave.
1950 Brock, Warren Heath, 16 Arcadia Rd.
1936 Kelly, J. Colman, Arcadia Rd.
1939 Read, Francis Arnold, 292 Sound Beach Ave.
1929 Shermak, Joseph V., 13 Arcadia Rd.

MONROE

Stepney Depot

1946 Williams, Francis Pryor Anthony

NEW CANAAN

1937 Abrahams, Meyer, 191 South
1949 Atchley, John Adams, Silver Hill, Valley Rd.
1951 Brown, David Seeley, 39 South Ave.
1952 Brown, Charlotte Rush, 39 South Ave.
1939 Cammann, Oswald DeNormandie, Oenoke Ave.
1941 Cody, Thomas Patrick, 222 South Main
1950 Coombs, Harrison Souder, 276 South Ave.
1938 DuBois, Franklin Smith, Silver Hill
1939 Frothingham, John Gerrish, Elm
1941 Hebard, George Whiting, Elm
1945 Hiden, Robert Battaile, Silver Hill
1935 Ludlow, George Craig, 8 Oenoke Ave.
1945 Pearce, Marvin Ghent, Silver Hill
1950 Scanlon, Wilson George, Box D
1935 Terhune, William Barclay, Silver Hill
1941 Twachtman, Eric, 28 Elm
1931 Wadsworth, Ruth Flanigen, Smith Ridge
1944 White, Ralph L., 178 South Main

NEWTOWN

1934 Clow, Henry Leon, Fairfield State Hospital
1927 Desmond, Waldo Fairfield, Main
1937 Egee, J. Benton
1941 Friedman, Samuel, Fairfield State Hospital
1940 Green, William Frederick, Fairfield State Hospital
1952 Jarrett, William Armistead, Fairfield State Hospital
1918 Knapp, Charles W., Taunton Rd., R. F. D. No. 1
1947 Kyle, George Byron, Glen Rd., Sandy Hook
1941 Oltman, Jane Elizabeth, Fairfield State Hospital
1943 Robey, Nathaniel Charles, Fairfield State Hospital
1936 Roy, Joseph Lambert, Castle Hill Rd.

NOROTON

1947 Beaman, G. Burnham, 322 Main

NOROTON HEIGHTS

1952 Colmore, John Palmer, 39 Fitch Ave.

NORWALK

1948 Barnett, Roy Nathaniel, Norwalk Hospital
1942 Bradley, E. Tremain, 417 West Ave. and 32 Elm, New Canaan
1933 Bucciarelli, John Anthony, 520 West Ave.
1941 Cody, George Richard, 119 West Ave.
1945 Corwin, Daniel Bernard, 463 West Ave.
1952 Corwin, Henry Richard, 85 East Ave.
1942 Davis, George Breed, 69 Aiken
1937 Diamond, Edward H., 15 Belden Ave.
1940 Fitzpatrick, Wesley Fenton, 85 East Ave.
1935 Fox, Robert Adolph, 520 West Ave.
1946 Gens, John Paul, 64 Wall
1947 Genvert, Harold, 75 East Ave.
1949 Gloetzner, Henry James, 75 East Ave.
1938 Gorham, Grace Viola, 64 Wall
1948 Ippolito, Thomas Leonard, 75 East Ave.
1945 Johnson, William Henry Nelson, Jr., 14 Leonard
1949 Kalaman, Francis J., 75 East Ave.
1915 Kellogg, Henry Kirke White, 725 West Ave.
1950 Longworth, Edmund F., 55 East Ave.
1949 Lyons, Benjamin Ephraim, 3 Belden Ave.
1948 Margold, Allen Montague, 148 East Ave.
1946 Mills, Clifford Wheeler, 65 East Ave.
1951 Norrington, Eric George, 119 West Ave. and 1 Avery Pl., Westport
1938 Northrop, Robert Arthur, 2 Park
1947 Ogden, Faith Newbury, 6 Stevens
1938 Padula, Ralph Domenick, 84 West Ave.
1929 Patterson, Frederick Arthur, 520 West Ave.
1942 Paul, Francis, 64 Wall
1930 Perkins, Charles Winfield, 520 West Ave.
1938 Piasecki, Joseph L., 520 West Ave.
1928 Scanlon, Thomas Francis, 394 West Ave.
1947 Serena, Frank A., 75 South Main
1950 Skluth, L. Herbert, 87 East Ave.
1952 Trambert, Harry L., 65 East Ave.
1938 Vollmer, John William, 654 West Ave.

South Norwalk

1936 Beck, Eugene Cornelius, 75 South Main
1946 Burack, Jason Oliver, 3 West Ave.
1938 Corridon, James Donald, 119 West Ave.
1943 Davis, James Sumner, 282 West Ave.
1922 Fawcett, George Gifford, 8 Washington
1941 Flanagan, Edwin Daniel, 141 West Ave.
1951 Flynn, Edward John, 276 West Ave.
1938 Giuliano, Louis Augustine, 84 West Ave.
1941 Green, H. Howard, 75 South Main
1940 Heafy, John Robert, 84 West Ave.
1938 Hunkemeier, Edna, 3 Washington
1951 Jones, Martling Barnet, 30 West Ave.
1938 Keys, Robert Cathcart, 84 West Ave. and 322 Main, Stamford
1952 Mandell, Marshall, 7 Washington
1941 McMahon, John David, 4 Washington
1923 McMahon, William Henry, Jr., 13 Washington
1951 Minor, James Vincent, Jr., 276 West Ave.
1946 Paley, Martin, 111 West Ave.
1938 Paris, Marcus, 34 West Ave.
1949 Rem, Edward, 272 West Ave.
1949 Richman, Daniel Powell, 30 West Ave.
1941 Rosenthal, Isidor, 72 South Main
1947 Rubin, David, 75 South Main
1943 Ryder, Clifford Fuller, 111 West Ave.
1939 Scanlon, John Joseph, 276 West Ave.
1946 Serena, John Mario, 111 West Ave.
1931 Simon, Louis Goodwin, 30 West Ave.
1943 Steinberger, Laszlo, 111 West Ave.
1937 Stietzel, Eric Ernst, 5 Washington
1938 Weinstein, Nathan, 111 West Ave.

REDDING

1941 Grevatt, Kenneth Lloyd

RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main
1944 Inkster, James Henry, 153 Main
1951 Kurtz, I. Maxwell, 26 Main
1946 Pease, Marshall Carleton, Branchville Rd.
1949 Rogers, Evelyn, 153 Main
1951 Safford, Theodore, Jr., 169 Main
1951 Wagner, Edward Joseph, 126 Main
1927 Woodford, Francis Bowditch, 62 Main

RIVERSIDE

1945 Meeker, D. Olan, Riverside Ave.

SHELTON

1945 Burns, Francis Michael, 499 Howe Ave.
1939 Edson, Ralph Howard, 77 Oak Ave.
1917 Finn, Edward James, 216 Coram Ave.
1930 Gaetz, Thomas Harold, Laurel Heights
1949 Hansen, Wilbur Henry, Soundview Ave.
1937 Howlett, Kirby Smith, Jr., Laurel Heights
1925 Lynch, Edward James, Laurel Heights
1941 Pagliaro, Joseph John, 433 Howe Ave.

SOUTHPORT

1947 Sterrett, Raymond A., 115 Main

SPRINGDALE

1940 Crane, James Everett, 1186 Hope
1949 Savak, Joseph Ernest, 833 Hope

STAMFORD

1946 Abrahamson, Robert Henry, 107 Glenbrook Rd.
1952 Adam, Alan Brown, 94 Prospect
1936 Bannon, Frederick Michael, 300 Main
1947 Barber, Richard Robbins, 77 Bedford
1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium
1927 Bissell, Addison Hayes, 65 South
1944 Blass, Gustaf, Stamford Hall
1948 Boshnack, Malcolm, 70 Strawberry Hill Ave.
1926 Bowman, Stuart Howard, 65 South
1928 Brown, Paul Hemingway, 140 Woodside Village
1951 Bullen, Halsey Graves, 1 Atlantic
1935 Carpenter, Robert Morse, 636 Summer
1937 Carwin, Joseph Lucian, Jr., 115 West Main
1944 Cassone, Rocco, 308 Atlantic
1950 Cloonan, John Joseph, 182 Seaton Rd.
1947 Cognetta, Armand B., 255 Bedford
1940 Cognetta, James John, 228 West Broad
1946 Colburn, Russell Fitch, 1416 Bedford
1942 Colmers, Rudolph Albert, 65 South
1940 Connolly, Joseph Patrick, 104 South
1937 Costanzo, James Joseph, 300 Main
1937 Cunningham, Robert D. M., 65 South
1934 D'Andrea, Frank Henry, 29 South
1938 Dean, Stanley Rochelle, 94 Prospect
1909 Dichter, Charles Levi, 33 Forest
1935 Dichter, Irving Samuel, 33 Forest
1947 DiFrancesco, Lindo Peter, 65 South
1951 Dobbins, James Matthew, Jr., 176 Cove Rd.
1937 Dorion, Robinson Harry, 610 Summer
1951 Epstein, Ezra Jacob, 59 Prospect
1952 Fakkel, Marie Josephine, 1187 Summer
1951 Farrell, John Raymond, 65 South
1950 Farrell, Richard Francis, 188 North
1947 Felding, Howard Anthony, 300 Main
1933 Fincke, C. Louis, 1 Atlantic
1937 Fine, Barnet, 70 Grove
1936 Fine, Joseph, 55 Forest Rd.
1931 Fiske, Madeline, 65 South
1948 Fogel, David Hudson, 1380 Bedford
1934 Friedberg, Solomon, 671 Bedford
1931 Gandy, R. Alfred, 65 South
1913 Gandy, Raymond Reeves, 65 South
1931 Giles, Newell Walton, 1 Atlantic
1949 Goldfarb, Simon L., 65 South
1945 Greenblatt, Jacob, 1675 Bedford
1947 Haine, John W., 636 Summer
1937 Harrison, Francis Murphy, 512 Atlantic
1930 Hertzberg, Reinhold Frederick, Diamond Crest Lane
1949 Howorth, Beckett M., 126 Bedford
1937 Hymovich, Leo, 1521 Summer
1944 Jaiven, Saul Joseph, 1521 Summer
1929 Keddy, Russell Alfred, Stamford Hospital
1951 Kemp, Walter Wyckoff, 65 South
1949 Kent, Edwin Head, 218 Bedford
1938 Kezel, Albert Patrick, 188 Graylock Pl.
1947 Klein, Harold T., 578 Summer
1939 Koffler, Arthur, 90 Glenbrook Rd.
1951 Lanman, Jonathan Trumbull, Long Ridge Rd.
1951 Layton, William Malloy, Jr., Stamford Hospital
1951 Levine, Harry Philip, 877 High Rd.
1951 Levine, Julian, 1521 Summer
1949 Little, David Mason, Jr., 50 Division
1948 MacKee, George Miller, Haviland Rd.
1934 Malloy, Edward Francis, 65 South
1948 Mancinelli, M. Joseph, 50 Division
1950 Mast, George Winfield, 58 Auldwood Rd.

1946 Mastrangelo, Angelo, Jr., 50 Division
1933 McFarland, Frederick William, 65 South
1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.
1935 McGourty, David Philip, 95 Hope
1948 McIntyre, Frederick Powers, 65 South
1924 McMahon, Frank Cash, 62 Suburban Ave.
1947 Meacham, Charles Thomas, 65 South
1930 Meschter, Eugene Funk, 52 Upland Rd.
1946 Miller, Hugh Kennedy, 1959 Summer
1936 Moore, Clifford Douglas, Stamford Hall
1949 Moriarty, James Patrick, 50 Division
1947 Mulaire, Victor J., 65 South
1951 Mulford, Edwin H., 2nd, 126 Bedford
1938 Murphy, Charles Anthony, 59 South
1931 Murray, Henry Joseph, 53 South
1940 Nemoitin, Bernard Oscar, 96 Main
1911 Nemoitin, Jacob, 96 Main
1952 Nolan, John Joseph, 65 South
1946 Ogilvie, John Black, 610 Summer
1938 O'Meara, Francis Patrick, 1 Elm Pl.
1928 Paul, Voyle Abrams, 65 South
1946 Pocabut, John Stephen, 65 South
1948 Raffaele, Frank Joseph, 159 Main
1938 Rawls, Cotton, 300 Main
1929 Resnik, William Harry, 65 South
1942 Robison, Roy Calvin, 65 South
1951 Rogers, James Forbes, 65 South
1926 Rose, Allison, 65 South
1951 Rosenberg, Bernard L., 65 South
1951 Ryan, John Joseph, 59 Prospect
1951 Ryan, William Arthur, 65 South
1946 Sabia, Daniel Joseph, 65 South
1932 Schmidt, Norman Louis, 60 Glenbrook Rd.
1930 Sette, Alfred Joseph, 78 Forest
1949 Sheard, Charles, 76 Glenbrook Rd.
1938 Sherman, Saul Harvey, 328 Atlantic
1950 Slater, Gertrude, 1675 Bedford
1941 Smith, Leo Michael, 65 South
1947 Snaveley, John Geoffrey, Stamford Hospital
1951 Sommers, Margaret, 159 Main
1942 Stankard, William Francis, 140 Forest
1934 Starrett, Jay Ellis, 970 Summer
1907 Staub, J. Howard, 100 South
1920 Stringfield, Oliver Linwood, 1416 Bedford
1949 Svedlow, Bernard Dave, 1767 Summer
1950 Tella, Ralph Thomas, 107 Glenbrook Rd.
1940 Troy, William Daniel, 758 Summer
1951 Veremakis, Constantine, 2 Bracewood Lane
1939 Washburn, Wendell James, 65 South, and 261 Lake Ave., Greenwich
1951 Way, Howard Sharples, 65 South
1947 White, William B., 805 Gurley Bldg.
1947 Wrona, Eugene Adam, 229 South
1949 Wyatt, Robert Harry, 77 Bedford

STRATFORD

1947 Anton, Michael Charles, 2390 Main
1938 Ashcroft, Allan Davis, 3585 Main
1947 Brown, Richard J., 2220 Main
1943 Dinan, H. Philip, 3466 Main
1949 Dunphy, Donal, 2857 Main
1936 Friedman, Nathan Harris, 2336 Main
1927 Haberlin, Chester Edward, 2944 Main
1950 Impellitteri, Thomas Joseph, 972 East Broadway
1939 Levy, Samuel Howard, 3007 Main
1934 Maher, John Rodden, 2184 Main
1931 Oesau, Harold Thomas, 1949 Main
1949 Olmsted, Richard Williams, 2857 Main
1940 Penner, Sidney Lincoln, 2692 Main
1942 Roberge, George Edward, 44 Plymouth
1950 Spinelli, Nicholas Patrick R., 2857 Main
1948 Steel, Robert MacDonald, 3585 Main
1942 Thomases, Saul, 2595 Main

TRUMBULL

Long Hill

1946 Corbett, William Tihamer, Box 158
1941 Hall, R. Warren, 31 Hilltop Dr., Nichols

WESTON

1947 DiBlanda, Harry A., Lyons Plains Rd.

WESTPORT

1952 Biskind, Morton Sidney, 28 Main
1948 Dickenson, James Rea, Parsell Lane
1930 Ellrich, David Lionel, 125 East State
1943 Gerow, George H., Westport Sanitarium
1943 Hart, J. Garwood, 67 Myrtle Ave.
1943 Houze, Harry G., Westport Sanitarium
1946 Isenman, Robert, 26 West State
1947 Lebhar, Neil F., Bay
1951 Locks, Matthew Owen, 142 Main
1950 Lynch, Franklin, Bay
1934 Morgan, William Oliver, 193 Main
1937 Nespor, Robert Wenzel, 1 Avery Place
1925 Phillips, Harry Shaw, 44 Church Lane
1952 Schultz, Martin, 121 Main
1941 Shoup, Homer B., Jr., 58 East State
1943 Solway, Reuben Isaac H., 450 Kings Highway
1950 Syz, Hans, The Lifwynn Foundation
1936 Teuscher, William Philip, 18 Compo Rd.

WILTON

1939 Knauth, Marjorie Strauss, Drum Hill Rd.
1948 Maidman, Leonard, Crossways

OUT OF COUNTY

1937 Aldwin, Francis Joseph, 185 Crown, Meriden
1952 Barringer, Phil Louis, P. O. Box No. 2, Windsor, North Carolina
1949 Bergeron, Lawrence Norbert, 48 Chestnut, Rochester, New Hampshire
1939 Brewer, Francis, 52 Jerome Ave., Bloomfield
1948 Coffin, S. Farnum, Jr., The Radcliffe Infirmary, Oxford, England
1943 Crispin, Maximilian A., St. Francis Hospital, Hartford
1947 Donadeo, John, 633 North Broad, Elizabeth, N. J.
1945 Fisher, Joseph G., c/o Clinique St. Nicholas, Cannes (A.M.) France
1951 Foret, Justillien, Cruz Bay, St. John, Virgin Islands, U. S. A.
1943 Golomb, Evelyn Francis, Sunny Acres Hospital, Richmond Rd., Cleveland, Ohio
1947 Hansell, Robert Joseph, 3908 Sussex Rd., Lancaster Court, Wilmington, Delaware
1951 Hoffman, Julius, 1866 Northwest Blvd., Columbus, Ohio
1912 Hyde, Charles Elias, 301 23rd Ave., N.E., St. Petersburg, Florida
1939 Ireland, Richard Milton, 66 Bridge, New Milford
1944 Kelemen, Eugene, Box 34, Camanillo, California
1913 Lambert, H. Bertram, Veterans Hospital, Rocky Hill
1946 Lenoci, Ralph Joseph, Boston City Hospital, Boston, Massachusetts
1948 Levine, Abraham I., V. A. Hospital, Newington

1949 Malone, Edward Henry, Louden-Knickerbocker Hall, Amityville, N. Y.
1952 Meunier, John Louis, Main, New Milford and 24 Church, Torrington
1939 Murray, Thomas Oscar, V. A. Hospital, New Orleans, La.
1947 O'Looney, John J., Jr., Veterans Hospital, White River Junction, Vermont
1948 Olsavsky, John Cyril, 7207 Forest Rd., Hyattsville, Maryland
1907 Pratt, Nathan Tolles, Old Saybrook
1941 Shain, Joseph H., 117 No. Krome Ave., Homestead, Florida
1909 Shirk, Samuel Martin, Masonic Home, Wallingford
1947 Siege, Alfred Geoffrey, USA Radio Station, APO843 N. Y.
1937 Strayer, Estella Morton, 3685 38th, N.W., Washington 16, D. C.
1942 Upham, Charles E. H., R. F. D., Boothbay, Maine
1949 Vessie, Percy, 100 Haven Ave., New York City

Hartford County Association

President: William H. Upson, 172 Main St., Suffield
Vice-President: Burdette J. Buck, 299 Farmington Ave., Hartford
Secretary-Treasurer: Thomas M. Feeney, 701 Asylum Ave., Hartford
Councilor: Maurice T. Root, 51 North Main St., West Hartford
Alternate Councilor: John N. Gallivan, 74 Connecticut Blvd., East Hartford
Business Office: 38 Prospect St., Hartford
Annual Meeting, First Tuesday in April
Semi-Annual Meeting, Fourth Tuesday in October

AVON

1913 Madden, Leon Irving, West Avon Rd.
1941 Wiepert, William Murray, Main
1949 Williams, William Edward, Main

BERLIN

1947 Foster, Hollis Joseph, Worthington Ridge

BLOOMFIELD

1949 Bagnall, Richard Salmon, 31 Tunxis Ave.
1936 Burgdorf, Alfred Louis, Duncaster Rd.

BRISTOL

1930 Appell, Paul Harry, 227 Main
1947 Baptist, Vincent, 32 Sherman
1934 Beatrice, Alphonse Anthony, 331 Main
1948 Becker, Arnold H., 124 Main
1936 Bird, Frederick Stanford, 124 Main
1932 Borkowski, Boleslaus Joseph, 4 School
1900 Brackett, Arthur Stone, 17 Broad View
1947 Brezina, Philip Savage, 161 Grove
1948 Brockway, Dorothy W., 205 Summer
1950 Burnett, Claude Armour, Jr., 75 High
1948 Claffey, Michael F., 81 Main
1947 Dalmain, Walter Andrew, 368 Main
1935 Flynn, William Henry, 9 North Main
1947 Furniss, William Ernest, 239 Belridge Rd.
1937 Hall, Martin Irving, 19 High
1946 Hanley, J. Bainbridge, 63 Bellevue Ave.
1921 Hanrahan, William Richard, 209 Center
1952 Hershey, David Daniel, 133 Main
1948 Hershman, Harry Herbert, 122 Maple
1938 Hudon, Frederick Alfred, 19 High
1928 LaPlume, Albert Antonio, 45 Prospect
1951 LaPorte, Thomas Francis V., 269 North Main
1942 Littwin, Ralph J., Bristol Hospital
1948 Marino, Rocco Serefin, Bristol Hospital
1929 Nestos, Peter Alexander, 63 Main
1935 Papa, John Smith, 124 Main
1952 Perry, Douglas Dards, 277 Main
1948 Pollock, Henry Meeker, Jr., 40 High
1946 Purney, John, 240 Main
1921 Richardson, Ralph Augustus, 40 High
1935 Siliciano, Raoul Andrew Victorius, 110 South
1936 Stevenson, William Robb, 240 Main
1939 Tirella, Fred Francis, 2 Riverside Ave.
1942 Vogel, Frank Siegfried, 301 Main
1934 Winters, Hyman W., 405 North Main
1914 Woodward, Harold Burton, 321 Main

CANTON

1949 Denton, G. Daniel

Collinsville

1906 Cox, Ralph Benjamin
1949 Diters, Edward Nelson, Main
1937 Phelps, Paul Stetson, R. F. D. No. 1

EAST HARTFORD

1948 Acqua, Louis C., 40 Elm
1951 Aune, Edwin Fjelde, 74 Connecticut Blvd.
1945 Carignan, Roland Zephin, 36 Sunset Ridge Rd.
1944 Curtis, Alton Kallock, 5 Broad
1948 Danyliw, Joseph Michael, 110 Main
1936 Gallivan, John Norman, 74 Connecticut Blvd.
1923 Haylett, Howard Bulkeley, 1109 Main
1951 Herman, Ralph Scallon, Jr., 400 Main
1946 Hervey, Zoltan P., 1169 Main
1933 Houle, Raymond Theodore, 5 Central Ave.
1952 Leo, Frank Joseph, 59 Burnside Ave.
1950 Lohman, William Henry, 63 Connecticut Blvd.
1934 Lublin, Raymond David, 759 Main
1939 Mirabile, Thomas Joseph, 59 Burnside Ave.
1947 Murphy, John Joseph, 27 Wells Ave.
1916 Onderdonk, Harrie Jay, 11 Central Ave.
1920 Schaefer, Jacob, 1011 Main
1948 Sirota, Harvey H., 1128 Main
1950 Sorokowski, George W., 110 Main
1942 Trantolo, Arthur, 1559 Main
1952 Welch, William J., Hamilton Standard Div., Main

EAST WINDSOR

Broad Brook

1923 Robinson, Wilford John Thomas, Main

Warehouse Point

1937 Maslak, Rudolph, South Main

ENFIELD

1943 Yerbury, Charles Calvin, 1070 Enfield

Hazardville

1906 Bridge, John Law, P. O. Box 272
1923 Shepherd, William Gordon, Main

Thompsonville

1937 Bloom, David Irving, 126 Pearl
1937 Dignam, Bernard Stephen, 133 Pearl
1938 Gourlie, Howard Wallace, 75 North Main
1950 Johnson, Carl Wentworth, 126 Pearl

1948 Robbins, Jacques, 17 North Main
1940 Valenski, Thaddeus James, Main

FARMINGTON

1946 Barbour, Paul Humphrey, Jr., 14 High
1933 Bunnell, Walls Willard, Main
1935 MacLean, Ethel Margaret, High

FORESTVILLE

1948 Longo, Vincent Francis, 205 Central

GLASTONBURY

1933 Earle, Benjamin Baylis, 2458 Main
1935 Griswold, Edwin Monroe, 2858 Main
1943 Pharris, Crit, 1252 Main
1939 Raffa, Joseph, 2638 Main
1946 Ricca, Renato A., 28 Ripley Rd.
1924 Whittles, Lee Jay, 2205 Main

HARTFORD

1942 Allen, George Francis, 279 Farmington Ave.
1941 Allen, John Clinton, Hartford Hospital
1944 Allen, Mary Mazner, 32 Lorraine
1927 Allen, Wilmar Mason, 64 Jefferson
1937 Andrews, Egbert Morrill, 85 Jefferson
1951 Angelini, Hugo Dominic, 18 Asylum
1927 Antupit, Louis, 242 Trumbull
1936 Apter, Harry, 99 Pratt
1932 Arons, Milton Robert, 750 Main
1904 Backus, Harold Simeon, 99 Pratt
1913 Bailey, N. Herbert, 109 North Whitney
1923 Bancroft, Harold Arthur, 85 Jefferson
1952 Bannister, William Kirtley, 80 Seymour
1947 Barbour, Charles Manson, Jr., 20 South Hudson
1940 Barker, Norman John, 55 Elm
1952 Barrett, Harold Spencer, 165 Capitol Ave.
1933 Bausch, Carl Philipp, 36 Pearl
1907 Beach, Charles Thomas, 42 Willard
1949 Beaky, John Francis, 703 Asylum Ave.
1929 Beatman, Israel, 242 Trumbull
1948 Beckett, Ronald Stewart, 20 South Hudson
1944 Beebe, John Taylor, 665 Asylum Ave.
1934 Beizer, Edmund, 56 Garden
1950 Bellizzi, Joseph John, 34 Sisson Ave.
1947 Bernstein, Louis, 85 Jefferson
1923 Bestor, Eugene Leonard, 36 Pearl
1936 Bingham, Charles Tiffany, 576 Farmington Ave.
1938 Birge, Henry L., 664 Farmington Ave.
1941 Bobrow, Aaron, 387 Blue Hills Ave.
1897 Botsford, Charles Porter, 219 Collins
1947 Bowen, Francis Dorsey T., 689 Asylum Ave.
1951 Braceland, Francis J., 200 Retreat Ave.
1941 Brandon, Kenneth Francis, 151 Farmington Ave.
1951 Brandriss, Joseph, 95 Pearl
1916 Branon, Anthony William, 85 Jefferson
1912 Brayton, Howard Wheaton, 576 Farmington Ave.
1931 Brecker, F. Wellington, 50 Farmington Ave.
1939 Brennan, Edward L., 56 Garden
1931 Brewer, Timothy Francis, 50 Farmington Ave.
1946 Brewster, William B., Jr., 111 Pearl
1952 Brown, Freeman Fletcher, Jr., 80 Seymour
1949 Bruno, Francis Ernest, 701 Asylum Ave.
1942 Bruskin, Chaim Elias, 1840 Park
1929 Buck, Burdette Jay, 299 Farmington Ave.
1931 Buckley, Richard Cotter, 111 Gillett
1948 Bunce, James Merrill, 85 Jefferson
1946 Burness, Sidney Harold, 111 Pearl
1950 Burns, John Edward, 350 Farmington Ave.
1928 Butler, Nicholas George, 50 Farmington Ave.
1949 Butterfield, Walter Lamont, Jr., 85 Jefferson
1930 Byrne, David Walter, 85 Jefferson
1950 Calio, James Vincent, 216 Farmington Ave.
1931 Calverley, Eleanor Jane Taylor, 143 Sigourney
1947 Campbell, Robert Harold, 85 Jefferson
1934 Cappiello, Silvestro, 47 Vine
1948 Carangelo, John, 402 Farmington Ave.
1933 Carey, Thomas Cornelius, 111 Gillett
1931 Carniglia, Ettore Francis, 85 Jefferson
1929 Carroll, James Edward, 220 Farmington Ave.
1948 Cartland, John Everett, Jr., 85 Jefferson
1937 Case-Downer, Muriel, 157 Warrenton Ave.
1949 Castagno, Marion MacDonald, 215 Washington
1949 Castagno, Rowe Anthony, 215 Washington
1930 Caulfield, Ernest Joseph, 683 Asylum Ave.
1933 Cenci, Vincent Peter, 64 Garden
1946 Chaucer, Norton G., 488 Main
1943 Chester, Lewis L., 179 Allyn
1950 Churchill, John Alvord, 85 Jefferson
1922 Clason, Freeman Pell, 85 Jefferson
1948 Clifford, Joseph Caleb, 151 Farmington Ave.
1937 Clifford, Martha Louise, 436 Capitol Ave.
1928 Cogan, George Eugene, 50 Farmington Ave.
1913 Cogswell, Eliot Sanborn, 179 Allyn
1936 Cogswell, Lawrence Perley, 85 Jefferson
1950 Cohen, Benjamin, 500 Blue Hills Ave.
1938 Cohn, Samuel Hills, 111 Pearl
1948 Cole, Milton Julius, 75 Pratt
1935 Connor, Joseph Joyce, 750 Main
1949 Conway, Edward Joseph, 576 Farmington Ave.
1933 Corcoran, Michael Anthony, 689 Asylum Ave.
1946 Cornwell, Philip Morba, 85 Jefferson
1944 Cramer, Sidney Leo, 64 Garden
1933 Crosby, Edward Harding, 50 Farmington Ave.
1941 Cullen, James Rescott, 350 Farmington Ave.
1946 Curran, Timothy Leonard, 50 Farmington Ave.
1938 Curtis, Burr Harding, 85 Jefferson
1914 Daly, Charles William, 247 South Whitney
1935 Daly, William Patrick, 342 Edgewood
1922 Davis, James Edward, 85 Jefferson
1951 Davis, Roger Wolcott, Jr., 85 Jefferson
1949 Day, Marvin Bunce, 576 Farmington Ave.
1909 DeBonis, Domenico A., 183 Westland
1952 Delgado-Fourzan, Enrique, 200 Retreat Ave.
1951 Della Pietra, Alfonso, 35 North Whitney
1946 Delligan, Francis William, 114 Woodland
1947 Deming, Archibald Staley, 85 Jefferson
1914 Deming, Clinton Demas, 85 Jefferson
1949 Deming, Edward Griswold, 85 Jefferson
1931 DePasquale, Francis Lawrence, 1992 Broad
1937 DePasquale, John Anthony, 50 Farmington Ave.
1946 Desmond, Charles Thomas, 683 Asylum Ave.
1934 DeVito, Michael Joseph, 525 Main
1931 Dion, Asa Joseph, 207 Washington
1944 Dion, Julien Andre, 207 Washington
1939 Dodd, Burwell, 85 Jefferson
1944 Doerr, William John, 179 Allyn
1951 Donnelly, John, 341 Washington
1948 Donnelly, William Allen, 689 Asylum Ave.
1934 Donner, Samuel, 99 Pratt
1938 Donovan, William Francis, 47 Main
1937 Duffy, Leo Thomas, 683 Asylum Ave.
1942 Duksa, Walter Joseph, 535 Main
1951 Dunsmore, Rembrandt Harvey, 85 Jefferson
1938 Durkee, Ralph Everett, Jr., 31 North Beacon
1946 Dushane, Joseph Edward, 297 Farmington Ave.
1947 Ebers, Theodore Martin, 140 Garden

1927 Elliot, K. Gregory, 631 Park
1943 Ellis, Lyle Gaffney, 700 Main
1948 Ellis, William Avery, 665 Asylum Ave.
1937 Ellison, Frederick Speirs, 85 Jefferson
1914 Emmett, Francis Arthur, 410 Asylum Ave.
1946 Englehart, Ernest Erwyn, 370 Blue Hills Ave.
1937 Fagan, Francis Xavier, 683 Asylum Ave.
1933 Farland, Victor Louis, 54 Pratt
1919 Fay, William James, 179 Allyn
1941 Feeney, Thomas Michael, 701 Asylum Ave.
1929 Felty, Augustus R., 50 Farmington Ave.
1942 Finesilver, Edward Max, 410 Asylum
1934 Finley, George Clark, 50 Farmington Ave.
1913 Flaherty, Claude Vincent, 50 Farmington Ave.
1951 Flaherty, Morgan Vincent, 50 Farmington Ave.
1943 Fleish, Milton Carl, 64 Garden
1949 Flynn, Frederick John, 85 Jefferson
1948 Foohey, Fleur Cornelius, 146 Jefferson
1947 Fortier, Norman Lionel, 99 Pratt
1925 Fox, James Charles, Jr., 85 Jefferson
1947 Franco, John Estrela, 50 Farmington Ave.
1931 Friery, Clarence Milton, 110 Greenfield
1943 Fritz, John, 656 Park
1919 Furniss, Henry Watson, 1337 Main
1927 Gaberman, David, 179 Allyn
1947 Gaines, Nemo Dexter, 700 Main
1937 Galinsky, David, 57 Wethersfield Ave.
1946 Gardy, Lawrence Andrew, 1731 Park
1921 Garland, Robert Bernard, 689 Asylum Ave.
1931 Geetter, Isador Stolper, 92 Fern
1949 Giardi, Leo Paul, 561 New Britain Ave.
1941 Gibson, Forrest Davis, 85 Jefferson
1946 Giffin, Lewis Albee, 85 Jefferson
1941 Gillespie, Harry, 983 Main
1934 Giorgio, Nicholas Anthony, 61 Edwards
1937 Giuliano, Sebastian, 468 Franklin Ave.
1943 Glass, William Henry, 11 Asylum Ave.
1934 Glaubman, Henry Mitchell, 18 Lenox
1946 Godfrey, Ellwood Watson, 85 Jefferson
1927 Goff, Charles Weer, 30 Farmington Ave.
1936 Gold, Louis Henry, 184 North Beacon
1930 Goldenberg, Jacob Joseph, 832 Albany Ave.
1949 Goldenthal, Carol, 576 Farmington Ave.
1947 Goldstein, Max Richard, 111 Pearl
1952 Goldstein, Theodore, 576 Farmington Ave.
1946 Golino, Emanuel Francis, 635 Main
1944 Golston, Harry, 750 Main
1933 Goodell, Robert Alvan, 79 Elm
1940 Goodrich, William Albert, 85 Jefferson
1950 Gordon, Yale, 781 Maple Ave.
1919 Gosselin, George Adelor, 50 Farmington Ave.
1946 Gottesfeld, Benjamin Harvey, 99 Pratt
1935 Gould, Max Martin, 434 Main
1923 Grau, Leroy Charles, 103 North Whitney
1939 Gray, Albert Stanley, 165 Capitol Ave.
1938 Gray, Harry Joshua, 750 Main
1943 Greene, Gerald S., 85 Jefferson
1930 Griggs, John Bolter, 650 Farmington Ave.
1948 Griswold, Dwight, 576 Farmington Ave.
1924 Griswold, Matthew Hammond, 165 Capitol Ave.
1941 Grossmann, Walter, 242 Trumbull
1947 Gurwitz, Jack, 179 Allyn
1949 Haines, Robert William, 85 Jefferson
1930 Hall, Llewellyn, 79 Elm
1939 Hall, Wendell Charles, 85 Jefferson
1947 Hamlin, Charles H., 85 Jefferson
1938 Harris, Louis David, 242 Trumbull
1936 Harvey, Daniel Foster, 218 North Beacon
1930 Hastings, Louis Pease, 114 Woodland
1937 Hazen, Donald Robert, 295 Farmington Ave.
1931 Hennessy, James Joseph, 50 Farmington Ave.
1946 Hepburn, Robert Hougton, 85 Jefferson
1907 Hepburn, Thomas Norval, 179 Allyn
1940 Heublein, Gilbert Whipple, 85 Jefferson
1930 Heyman, Joseph, 410 Asylum
1949 Hickcox, Curtiss Bronson, 80 Seymour
1934 Hirschfeld, Otto Max, 1037 Albany Ave.
1931 Hirschberg, Manuel Shelton, 135 Blue Hills Ave.
1951 Hockmuth, Lloyd Norton, St. Francis Hospital
1925 Hoffman, Charles Curtis, 700 Main
1924 Hogan, Walter Louis, 750 Main
1930 Holtz, Raymond Sidney, 7 Woodland
1945 Hopper, Jerome Murray, 50 Farmington Ave.
1935 Hough, Perry Tyler, 85 Jefferson
1949 Howard, Laura Koon, 200 Retreat Ave.
1950 Howe, Edward Redfield, Hartford Hospital
1922 Howe, Glover Elbridge, 85 Jefferson
1952 Hunter, Robert, 80 Seymour
1936 Hurwitz, George Hillel, 99 Pratt
1917 Hutchison, James Elder, 665 Asylum Ave.
1937 Irving, James Grant, 151 Farmington Ave.
1939 Jackson, Allen Francis, 2137 Main
1944 Jacobson, Charles Edward, Jr.. 50 Farmington Ave.
1934 James, Lewis Paul, 350 Farmington Ave.
1941 January, Derick Algernon, 85 Jefferson
1948 Jennings, Walter Forfar, 30 Farmington Ave.
1940 Jenovese, Joseph Francis, 85 Jefferson
1951 Johnson, James C., Jr., 85 Jefferson
1941 Johnson, Paul, 85 Jefferson
1930 Jones, Frank Stafford, 85 Jefferson
1928 Kalin, Jacob Isaac, 725 Asylum Ave.
1951 Kardys, Frederick Joseph, 80 Farmington Ave.
1933 Kardys, John Albert, 487 Main
1935 Karotkin, Robert Harold, 816 Albany Ave.
1945 Karpe, Richard, 801 Farmington Ave.
1935 Kaschmann, Joseph, 179 Allyn
1937 Katz, Dewey, 99 Pratt
1924 Katz, Henry, 750 Main
1941 Katzman, Samuel Sidney, 11 Asylum
1950 Kay, Richard, Hartford Hospital
1949 Kearney, Maurice Walter, Jr., 50 Farmington Ave.
1926 Keefe, George Gregory, 30 Sisson Ave.
1934 Keefe, Raymond Starkey, 272 Franklin Ave.
1934 Keefe, Walter Joseph, 350 Farmington Ave.
1951 Keet, John E., 86 Dauntless Lane
1908 Keith, Albert Russell, 85 Jefferson
1920 Kelly, Claude Currie, 85 Jefferson
1950 Kemler, Raphael Leonard, 576 Farmington Ave.
1930 Kendall, Ralph Emerson, 20 South Hudson
1927 Kilbourn, Austin, 1039 Asylum Ave.
1920 Kilbourn, Joseph Birney, 36 Pearl
1946 Kirsch, Neville, 56 Garden
1932 Klein, Abraham Arthur, 139 Fern
1946 Klein, Joseph, 80 Farmington Ave.
1951 Knoff, William Frederick, 200 Retreat Ave.
1944 Krall, Irving Hadley, 99 Pratt
1930 Kunkel, F. Earle, 85 Jefferson
1949 Lahey, William J., St. Francis Hospital
1901 Lampson, Edward Rutledge, 175 North Beacon
1938 Lampson, Rutledge Starr, 85 Jefferson
1913 Landry, Arthur Bernard, 50 Farmington Ave.
1926 Landry, Benedict Bernard, 50 Farmington Ave.
1940 Lankin, Joseph John, 85 Jefferson
1943 Lapenta, Rocco George, 1307 Albany Ave.
1949 Laramore, Herbert Franklin, 140 Garden
1929 Larrabee, John Whitfield, 85 Jefferson
1946 Larson, Albert Lloyd, 700 Main
1952 Lasser, Leonard Marshall, 270 Farmington Ave.

1950 Lear, Harold A., 111 Pearl
1942 Lenehan, John Richard, 683 Asylum Ave.
1938 Leonard, John Charles, 20 South Hudson
1933 Levin, Albert Eliot, 242 Trumbull
1946 Levin, Robert Raphael, 99 Pratt
1935 Levine, Sinclair Simcha, 54 Church
1936 Lewis, Samuel Donald, 85 Jefferson
1948 Liberson, Miriam, 62 Roslyn
1952 Liberson, Wladimir Theodore, 80 Seymour
1951 Lieben, Jan, 274 Farmington Ave.
1937 Lischner, Moses David, 75 Pearl
1946 Litter, Leo, 44 Garden
1934 Little, Milton Frederick, 85 Jefferson
1915 Locke, Harry Leslie Franklin, 293 Farmington Ave.
1952 Loftus, James Francis, 350 Farmington Ave.
1941 'Lowell, W. Holbrook, Jr., 85 Jefferson
1923 Luby, Thomas John, 410 Asylum
1919 'Maislen, Samuel, 2138 Main
1952 Mancall, Irwin Tuch, 750 Main
1931 Mancoll, Morris Max, 242 Trumbull
1949 Mann, Norman Morton, 99 Pratt
1943 Marinaro, Nicholas Anthony, Cedarcrest
1951 Marino, Frank Sebastian, 18 Asylum
1932 Marranzini, Samuel, 701 Asylum Ave.
1952 Marsh, Alexander, 34 Sisson Ave.
1946 Martin, Stevens John, 114 Woodland
1948 Mastronarde, Nicholas Angelo, 701 Asylum Ave.
1949 McCarthy, Frank Walden, Jr., 576 Farmington Ave.
1930 McClellan, Wilbert Ernest, 75 Pearl
1938 McCrann, Donald Joseph, 50 Farmington Ave.
1937 McCue, Martin P., 350 Farmington Ave.
1934 McDermott, John Francis, 56 Garden
1933 McGrath, John Francis, 663 Maple Ave.
1932 'McLellan, Philip Garretson, 85 Jefferson
1935 McNulty, Terence Francis, 21 Sisson Ave.
1949 McPherson, Sidney R., 85 Jefferson
1933 Middlebrook, Louis Francis, 85 Jefferson
1937 Miller, Harry Bernard, 983 Main
1947 'Miller, Seymour M., 1711 Park
1933 'Mirabile, Charles Samuel, 85 Jefferson
1946 Missett, James Stephen, 665 Asylum Ave.
1947 Moher, James J., 689 Asylum Ave.
1948 'Morrison, Donald Richard, 85 Jefferson
1909 Morrissey, Michael Joseph, 18 Asylum
1927 Moylan, Thomas Patrick, 50 Farmington Ave.
1930 Moyle, Henry Brown, 79 Farmington Ave.
1942 Mulville, Maurice Francis, 216 Farmington Ave.
1938 Neidlinger, William James, 85 Jefferson
1946 Nichols, Edward, 85 Jefferson
1947 Nichols, Frederick L., 85 Jefferson
1952 Nicholson, Richard Edwin, 140 Garden
1948 Nolan, John O'Leary, 50 Farmington Ave.
1950 Nurnberger, John Ignatius, 200 Retreat Ave.
1944 O'Connell, John Daniel, 50 Farmington Ave.
1923 O'Connell, John Francis, 865 Park
1928 O'Connell, Maurice Francis, 50 Farmington Ave.
1928 'Ogden, Ralph Trafton, 85 Jefferson
1949 O'Keefe, David Francis, 30 Sisson Ave.
1931 'Olmsted, John Gerald Maurice, 404 Farmington Ave.
1937 'O'Neill, Charles William, 18 Asylum
1921 'Osborn, Stanley Hart, 165 Capitol Ave.
1927 Osmond, Robert Hunter, 85 Jefferson
1938 Padula, Vincent Domenica, 1210 Broad
1945 Paladino, Joseph Salvatore, 300 Franklin Ave.
1938 'Peacock, Albert Upham, 576 Farmington Ave.
1952 Pepper, Dickinson Sergeant, 140 Garden
1944 'Perkins, Joseph Augustine, 50 Farmington Ave.
1933 Phelps, Maxwell Overlock, 85 Jefferson
1949 Piacente, Salvatore Sylvester, 701 Asylum Ave.
1947 Pierce, Harold Fisher, 165 Capitol Ave.
1929 Pike, Maurice Mitchell, 85 Jefferson
1944 Pitegoff, Gerald Irving, 242 Trumbull
1948 Pizzo, Paul S., 662 Wethersfield Ave.
1950 Polivy, Charles, 111 Pearl
1952 Porter, Edward Chandler, 85 Jefferson
1948 Prestley, William Francis, 85 Jefferson
1934 Priddy, Foster Eugene, 80 Farmington Ave.
1949 Pulaski, John Edward, 98 Main
1950 'Pyrtek, Ludwig Joseph, 85 Jefferson
1936 'Quarrier, Sidney Sayre, 85 Jefferson
1923 Radin, Morris Jacob, 36 Pearl
1928 Radom, Myron Michael, 242 Trumbull
1950 Rand, Paul King, Jr., 700 Main
1923 Rankin, Bertrand Fred, 57 Pratt
1951 Rankin, Clair, 137 Jefferson
1913 Reardon, William Francis, 750 Main
1950 Reed, John Francis, 85 Jefferson
1934 Reidy, D. Dillon, 750 Main
1928 'Reynolds, Harry St. Clair, 410 Asylum
1916 'Reynolds, Harry Stephen, 18 Asylum
1930 Reynolds, Robert Gardner, 85 Jefferson
1951 Riege, David Halsted, 576 Farmington Ave.
1922 Roberts, Douglas James, 85 Jefferson
1932 Robinson, Albert James, 55 Elm
1949 Robinson, Benjamin Rowland, 85 Jefferson
1950 Robinson, David, 99 Pratt
1943 Rocco, Mario P., 1125 New Britain Ave.
1948 Roh, Charles Ernest, 85 Jefferson
1934 Rollins, Henry Brock, 140 Garden
1936 'Rosenbaum, George Jonas, 647 New Britain Ave.
1938 'Rosenthal, Ernest, 18 Asylum
1935 Roth, Frank Edward, 179 Allyn
1907 Rowley, Robert Lee, 241 North Oxford
1951 Rowley, Samuel Dunham, 576 Farmington Ave.
1946 Rubin, Albert, 242 Trumbull
1950 Rubio, Mauricio, 200 Retreat Ave.
1947 Rup, Edward Carl, 525 Main
1921 Russell, G. Gardiner, 85 Jefferson
1936 Ryan, Francis James, 95 Pearl
1945 Sachs, Benjamin, 610 Farmington Ave.
1951 Sachs, Julius Johnson, 99 Pratt
1923 St. John, Leopold Albert, 25 Charter Oak Ave.
1950 St. John, Nicholas E., 25 Charter Oak Ave.
1926 Salvin, Benjamin Lloyd, 242 Trumbull
1937 Sayers, John Joseph, 865 Park
1928 Scafarello, Peter Joseph, 410 Asylum
1932 Schaefer, Abraham Maurice, 262 Maple Ave.
1949 Schloss, Walter Amson, 99 Pratt
1947 Schnap, Isidore, 95 Pearl
1946 Schwartz, Herbert Norman, 99 Pratt
1940 Scoville, William Beecher, 85 Jefferson
1932 Seibert, Alfred Frank, 700 Main
1948 Seigle, Stewart Pinnell, 85 Jefferson
1952 Sennett, Edward Joseph, 114 Woodland
1942 Serbin, A. Frederick, 99 Pratt
1941 Sewall, Sydney, 64 Garden
1920 Shea, Daniel Edward, 137 North Whitney
1944 Shepard, Marguerite Dunbar, Cedarcrest
1947 Sherwood, Paul Michael, 95 Pearl
1951 Shoukimas, John, 44 Garden
1941 Shull, John Coulter, 85 Jefferson
1933 Shulman, David Nathaniel, 422 Farmington Ave.
1932 Sigal, Jacob Bernard, 179 Allyn
1948 Silberman, Josef Salo, 179 Allyn
1940 Silver, Gershon Benjamin, 439 Farmington Ave.
1949 Sinclair, Edmond Brown, State Dept. Health
1936 'Slossberg, David Seymour, 541 Park
1945 'Smith, Charles Leonard, 85 Jefferson

1927 Smith, William Bowers, 80 Farmington Ave.
1944 Smith, William Leslie, 85 Jefferson
1939 Smith, Wilson Fitch, 85 Jefferson
1937 Sneidman, George Irving, 322 Vine
1929 Snelling, Pinckney Welch, 111 Pearl
1944 Solomkin, Mark, 750 Main
1935 Solomon, Charles Isadore, 576 Farmington Ave.
1943 Solomon, Rebecca Zincher, 576 Farmington Ave.
1937 Spekter, Louis, 436 Capitol Ave.
1921 Spillane, Bernard, 30 Farmington Ave.
1951 Spillane, Richard, 30 Farmington Ave.
1941 Sponzo, James Joseph, 3 Webster
1927 Standish, E. Myles, 85 Jefferson
1897 Standish, James Herbert, 85 Jefferson
1931 Standish, Welles Adams, 85 Jefferson
1946 Steege, Theodore Walter, Hartford Hospital
1930 Steincrohn, Peter Joseph, 705 Asylum Ave.
1949 Steven, Ranald James, 80 Seymour
1923 Storrs, Ralph Warren, 85 Jefferson
1951 Studenski, Eugene R., 500 Blue Hills Ave.
1949 Sunkin, David Frederick, 656 Blue Hills Ave.
1907 Swan, Horace Cheney, Trinity College
1948 Swett, Norris Poole, 85 Jefferson
1932 Talbot, Henry Pierce, 165 Capitol Ave.
1948 Teahan, John William, 689 Asylum Ave.
1950 Thau, Marcel, 279 South Marshall
1949 Thayer, John Ernest, 114 Woodland
1922 Thompson, Hartwell Greene, 85 Jefferson
1938 Tonken, Louis Clarence, 487 Farmington Ave.
1938 Tovell, Ralph Moore, 20 South Hudson
1930 Townsend, Wilmot Charles, 301 Farmington Ave.
1942 Truex, Edward Hamilton, Jr., 85 Jefferson
1908 Tuch, Morris, 99 Pratt
1946 Tucker, Charles Albert, 85 Jefferson
1950 Tulin, George Arthur, 111 Pearl
1907 Turbert, Edward Joseph, 703 Asylum Ave.
1947 Turco, Vincent Joseph, 56 Garden
1937 Twaddle, Paul Holmes, 85 Jefferson
1937 Unsworth, Arthur Charles, 85 Jefferson
1933 Uricchio, Joseph George, 260 Wethersfield Ave.
1908 Vail, George Francis, 36 Pearl
1923 VanKleeck, Euen, 700 Main
1904 VanStrander, William Harold, 945 Asylum Ave.
1926 VanWart, William Haley, 650 Main
1917 Vernlund, Carl Frithiof, 85 Jefferson
1952 Vernlund, Robert James, 85 Jefferson
1951 Vicas, Benedict, 328 Campfield Ave.
1950 Vigue, Charles Everett, 200 Retreat Ave.
1948 Von Salzen, Charles F., 725 Asylum Ave.
1940 Walker, Robert, 85 Jefferson
1932 Wallace, Charles Kenneth, 700 Main
1934 Wallace, Victor G. H., 45 Retreat Ave.
1950 Waltman, Irving, 85 Jefferson
1937 Walton, Loftus Linwood, 137 Jefferson
1950 Wardner, LeRoy Hamilton, 85 Jefferson
1932 Warring, Howard Lewis, 1756 Main
1949 Watters, Franklin Benjamin, 85 Jefferson
1946 Wawro, N. William, 85 Jefferson
1946 Weed, Chester Albert, 85 Jefferson
1934 Weiner, Julius Gills, 750 Main
1943 Weiner, Sylvia, 242 Trumbull
1931 Weisenfeld, Nathan, 608 Blue Hills Ave.
1936 Weissenborn, Walter, 50 Farmington Ave.
1920 Weld, Stanley Burnham, 85 Jefferson
1916 Wells, Donald Breckenridge, 85 Jefferson
1943 Wells, Elizabeth C., 436 Capitol Ave.
1948 Wells, Gideon Robbins, 576 Farmington Ave.
1947 Wells, John Breckenridge, 85 Jefferson
1924 Whalen, Edward Joseph, 750 Main
1938 Whitcomb, Benjamin Bradford, 85 Jefferson
1938 White, Benjamin Vroom, 85 Jefferson
1946 White, Edward Philip, 689 Asylum Ave.
1942 Whiting, Richard Charles, 700 Main
1907 Wiedman, Otto George, 85 Jefferson
1951 Wiese, Chester Albert, 576 Farmington Ave.
1948 Wiesel, Benjamin, 85 Jefferson
1943 Wilson, Archibald Cameron, 55 Elm
1930 Wilson, William Augustus, 841 Asylum Ave.
1941 Wineck, Morris Samuel, 179 Allyn
1951 Winick, Nathan Max, 179 Allyn
1951 Wood, Dwight Reynolds, 85 Jefferson
1933 Wood, Frank Oliver, 85 Jefferson
1934 Woodford, Chester North, 703 Asylum Ave.
1949 Woodruff, John Harrison, 85 Jefferson
1916 Worthen, Thacher Washburn, 85 Jefferson
1922 Wright, William Witter, 700 Main
1932 Wulp, George Adolf, 50 Farmington Ave.
1928 Zariphes, Constantine Argyros Paleslogos, 487 Main
1947 Zarkin, Oscar Howard, 99 Pratt
1948 Zeldis, Norman, 449 Albany Ave.
1934 Zeman, Burnhardt, 983 Main
1946 Zeman, Michael Saxe, 111 Pearl
1948 Zimmerman, Leon Ward, 664 Farmington Ave.

KENSINGTON

1948 Chotkowski, Ludmil Adam, 538 Farmington Ave.

MANCHESTER

1937 Barry, Joseph Charles, 156 Main
1946 Besser, Edward Lambert, 17 Haynes
1924 Boyd, Howard, 935 Main
1940 Diskan, Albert Elmer, 29 Haynes
1951 Hamblet, John Brewster, Manchester Memorial Hospital
1952 Healy, Thomas McLean, 249 Main
1949 Helfrick, Francis Woodrow, 29 Haynes
1949 Helfrick, Sylvia Merrill, 186 East Center
1950 Horton, Frank Hamilton, 935 Main
1936 Keeney, Robert Raymond, Jr., 29 Haynes
1925 Knapp, Robert Phineas, 146 Hartford Rd.
1946 Lechausse, Ralph M., 470 Main
1950 Lehmus, Harold, 29 Haynes
1948 Lockward, Howard Jefferson, 17 Haynes
1947 March, Florence, 417 East Center
1946 Massaro, Joseph, 52 Park
1946 Miller, Gerard Roland, 755 Main
1950 Morrison, Donald William, 17 Haynes
1951 Moyer, Winfield Tyson, Jr., 342 Main
1945 Peckham, Charles Henry, 17 Haynes
1949 Platz, Edward John, 215 Hollister
1945 Prignano, John Vincent, 5 Middle Turnpike, West
1947 Rosen, Theodore, 808 Main
1951 Rubinow, Merrill Benjamin, 843 Main
1951 Schardt, Walter Mallory, 935 Main
1941 Segal, Jacob A., 413 Main
1937 Sundquist, Alfred Bernhardt, 17 Haynes
1950 Thomas, Andrew Henry, 12 Myrtle
1950 Weden, Elmer Alford, 43 Brookfield
1936 Zaglio, Edmond Robert, 12 Myrtle

South Manchester

1926 Caldwell, David Manchester, 935 Main
1926 Friend, Amos Edgar, 935 Main
1921 Lundberg, George Albin Ferdinand, 755 Main
1930 Moriarty, Mortimer Emmett, 905 Main

NEW BRITAIN

1948 Bellach, Harry, 300 Main
1932 Benoit, Raoul Joseph, 51 Cedar
1947 Berger, Alfred Jacob, 235 West Main
1934 Bernstein, Dwight J., 55 West Main
1930 Blogoslawski, Walter Joseph, 199 West Main
1935 Bristoll, Donald Andrews, 32 Grove Hill
1940 Buccheri, Francis Salvatore, 19 South High
1927 Buol, Robert Stanley, 99 West Main
1952 Callahan, James Lawrence, 50 Grove
1951 Canzonetti, Andrew Joseph, 55 West Main
1947 Carlson, Carl Edwin, 55 West Main
1926 Chernaik, Samuel Julius, Box 1194
1946 Clark, Bliss Bartlett, 32 Grove Hill
1945 Clarke, Harold Metcalfe, 99 West Main
1948 Cornfield, Elizabeth, 300 Main
1939 Daley, Louis William, 32 Grove Hill
1938 Dalton, George Henry, 1462 Stanley
1931 Darrow, John Edward, 55 West Main
1928 Donnelly, Stephen Patrick, 55 West Main
1941 Dorian, Edward, 300 Main
1941 Dorian, George David, 55 Grove Hill
1934 Dray, Edward Joseph, 259 Main
1947 Dunn, Morris L., 99 West Main
1942 Eisenberg, Sidney Edwin, 55 West Main
1941 Goldschmidt, Myer, 25 Arch
1943 Greenblatt, Harold Joseph, 99 West Main
1937 Hart, Carl Jay, 259 Main
1949 Irvin, John S., The Stanley Works
1949 Johnson, Roswell Dorr, 32 Grove Hill
1930 Kalett, Joseph, 55 West Main
1951 Kaplan, Henry Morris, 52 Main
1942 Kraszewski, Henry Walter, 49 Lexington
1942 Lacava, John James, 300 Main
1946 Larkin, John Charles, New Britain General Hospital
1951 Lee, William, Stanley Works
1946 Levine, Howard, 32 Grove Hill
1948 Livingston, William T., 32 Grove Hill
1938 LoVetere, Angelo Arthur, 29 Park Pl.
1948 Mainer, Raymond George, 55 West Main
1948 Martin, Edward, 32 Grove Hill
1930 Matteis, Joseph Theodore, 55 West Main
1939 McMahon, George William, 419 Main
1946 Mellion, Jacob, Walnut Hill School
1934 Michalowski, Valerian Stanislaus, 300 Main
1946 Mlynarski, Joseph Andrew, 43 Cedar
1949 Monti, Lyle John, 60 Lenox Pl.
1935 Moorad, Philip Jacob, 69 Lexington
1923 Mouradian, Marion Garoudy, 87 Prospect
1940 Nevulis, Anthony V., 32 Grove Hill
1938 Orbach, Egmont Julius, 81 West Main
1939 Paolillo, Charles Gerald, 55 West Main
1938 Parlato, Harry Anthony, 55 West Main
1944 Peck, Bernard Carl, 32 Park Pl.
1938 Perakos, George Peter, 32 Grove Hill
1939 Pola, William Edward, 324 Elm
1936 Resnik, Edward 272 Main
1940 Rosahn, Paul Dolin, New Britain General Hospital
1950 Sachs, Julian A., 1493 Stanley
1930 Schechtman, Charles Theodore, 81 West Main
1931 Schupack, Samuel David, 99 West Main
1938 Scully, Roger Tehan, 55 West Main
1930 Slysz, Ladislaus Bernard, 247 West Main
1928 Smith, Vincent Joseph, 55 West Main
1936 Squillacote, Vincent Joseph, 55 West Main
1938 Sullivan, Charles Noyes, 55 West Main
1940 Tisher, Paul Winslow, 99 West Main
1935 Tokarczyk, John Joseph, 32 North
1941 Trapp, Francis W., 55 West Main
1928 Waskowitz, David, 81 West Main
1934 Watson, William James, 223 West Main
1948 Wesoly, Andrew Stanley, 27 Grove Hill
1932 White, John Cowles, 32 Grove Hill
1941 Wilson, Dwight E., 32 Grove Hill
1949 Wise, Raymond Thomas, 25 Arch
1948 Wolfson, Samuel, New Britain General Hospital
1950 Wright, Ralph C., 32 Grove Hill
1948 Yannello, Mario Humbert, 55 West Main
1948 Young, Henry McGill, 31 Franklin Sq.
1945 Zwick, Frank, 35 South High

NEWINGTON

1950 Arst, Daniel Benjamin, Veterans Hospital
1946 Beardsley, Lewis George, Veterans Hospital
1948 Cavalieri, Rinaldo Joseph, 1100 Main
1942 Freeman, John Jay, 1247 Main
1946 Friedberg, Isadore Hirsh, 1078 Main
1946 Hurwitz, Alfred, Veterans Hospital
1946 Kunkel, Paul, Veterans Hospital
1946 O'Neil, Vincent Danforth, 26 Walsh Ave.
1950 Selesnick, Sydney, 555 Willard Ave.
1933 Whitty, Charles Aloysius, Cedarcrest
1947 Yesner, Raymond, Veterans Hospital

PLAINVILLE

1931 Cook, George Francis, 4 East Main
1931 Frost, Lawrence Hubbard, 98 West Main
1943 Iannotti, John Pasquale, 78 Whiting
1934 Menousek, Joseph Albert, 75 East Main
1909 Rooney, James Francis, 19 Crown
1938 Tortolani, Aresto Peter, 51 Maple

PLANTSVILLE

1937 Connor, George Michael, 772 South Main

ROCKY HILL

1949 Covalt, Nila Kirkpatrick, Veterans Hospital
1920 Geraci, Lucian Arthur, Veterans Hospital
1948 Moser, David Woods, 21 Elm
1904 Moser, Oran Alexander, Elm
1946 Walker, Donald Albert, 253 Main

SIMSBURY

1949 Edelberg, Eileen Kathleen, Hopmeadow
1949 Edelberg, Herman, Hopmeadow
1925 Murphy, Owen Lee, Weatogue
1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

1949 D'Angelo, Anthony James, 94 Center
1949 D'Angelo, Eugene Joseph, 94 Center
1935 Dudac, Thomas William, 9 Center
1933 Gura, George Michael, 22 Main
1935 Nagle, William Thomas, 23 Woodruff
1929 Simmons, Eric Melville, 93 Main
1947 Stetson, Harold Prescott, 162 Main
1929 Thalberg, Reuben Edward, 32 North Main

SUFFIELD

1948 Bard, Donald Gibson, Jr., 180 Main
1938 Coates, S. Paul, 328 Main
1930 Upson, William Hart, 172 Main

UNIONVILLE

1937 Dunne, Edward Patrick, Main
1941 O'Connell, Enos Joseph, 63 Main

WEST HARTFORD

1949 'Allen, Roy, 1001 Farmington Ave.
1950 'Anderson, James O., 797 Farmington Ave.
1903 'Brainard, C. Brewster, 10 Mountain View Dr.
1937 Burns, Maudie Marie, 30 Sulgrave Rd.
1942 Canby, Joseph Edward, 25 Mountain View Dr.
1949 'Carson, Joseph Peter, 1001 Farmington Ave.
1915 Carter, Earle Buell, 17 Hickory Lane
1931 Case, Edward Percy, 28 Brunswick Ave.
1905 Clifton, Harry Coltman, Box 218
1932 Crawley, George Andrew, 330 Park Rd.
1928 Cushman, Laurence Arnold, 23 South Main
1914 'Deming, Edward Adams, 15 Bainbridge Rd.
1910 Denne, Thomas Harmon, 39 North Main
1948 Dorfman, Jacob, 90 Whitman Ave.
1942 Edson, Reginald Campbell, 174 Arundel Ave.
1949 Fairlie, Chester Wilson, Jr., 142 Steele Rd.
1932 Filson, Ralph Marshall, 54 Crestwood Rd.
1943 Fox, George Francis, 8 Hooker Dr.
1922 Gills, William Lee, 21 Banbury Lane
1926 Glazier, J. Raymond, 26 Sequin Rd.
1939 Hollinshead, Joseph Bentley, 1064 Farmington Ave.
1942 'January, Mildred Hartshorn, 1020 Prospect Ave.
1912 Jarvis, H. Gildersleeve, 40 Ledyard Rd.
1906 Kingsbury, Isaac W., 26 Northmoor Rd.
1944 Klein, Rose Herchman, 58 Flagg Rd.
1920 Leak, Roy Lathen, 363 Ridgewood Rd.
1932 Lundborg, Francis Ludwig, 35 North Main
1951 Markley, D. Norman, 998 Farmington Ave.
1935 'Martin, John Garthwaite, 7 South Main
1950 McKnight, Robert Scott, 16 Beechwood Rd.
1916 'Miller, James Raglan, 7 Banbury Lane
1935 'Murphy, Thomas Francis, 683 Asylum Ave.
1948 'Northrup, Harriet Ellen, 36 West Beacon
1930 'Parshley, Philip Ford, 818 Farmington Ave.
1926 Partridge, Winthrop Prescott, 1043 Farmington Ave.
1943 Preston, Thomas R., 119 Bainbridge Rd.
1940 'Roche, Arthur F., 69 Newport Ave.
1937 Rogers, Frederick Peckham, 11 Ballard Dr.
1924 Root, Maurice Timothy, 51 North Main
1935 'Root, Sophie Andrews, 51 North Main
1910 Rowley, John Carter, 31 Wyndwood Rd.
1948 Russo, Joseph Nicholas, 15 Paxton Rd.
1947 Schatten, Siegfried Sylvester, 1157 New Britain Ave.
1945 Seideman, Roy Milne, 261 South Main
1949 'Shreve, Robert Wilton, 10 North Main
1901 Smith, E. Terry, P. O. Box 42
1935 'Standish, Hilda Crosby, Greenridge Lane, Sunset Farm
1936 Stewart, Lester Quentin, 77 South Main
1941 'Sullivan, Arthur Bland, 10 North Main
1939 'Tennant, Robert, 156 Walden
1921 Thenebe, Carl Leonard, 720 Farmington Ave.
1921 'Vershbow, Nathan, 250 Auburn Rd.
1942 Wells, Jean, 1013 Farmington Ave.
1931 Wienski, John Casimer, 115 Mountain Rd.
1934 Winters, John Thomas, 10 North Main
1904 Witter, Orin Russell, 7 Ledyard Rd.

Elmwood

1946 Baskin, Abraham Hyman, 422 New Britain Ave.
1946 Calef, Bension, 1157 New Britain Ave.
1932 Romaniello, Rocco John, 1086 New Britain Ave.

WETHERSFIELD

1938 Carvey, Edward Vincent, 1 Garden
1946 'Hellijas, Carl Sylvester, 4 River Rd.
1933 'Howard, Harold Amasa, 330 Main
1946 Messina, Michael C., 662 Wolcott Hill Rd.
1949 Murphy, Robert Daniel, 687 Wolcott Hill Rd.
1932 'Storms, William Frederick, 147 Main
1940 'Warren, Henry Stanley, 184 Main
1950 'Zyla, Edward J., 20 Timber Trail

WILSON

1949 Donohue, Stephen Michael, 408 Windsor Ave.

WINDSOR

1950 Gundling, Cyril A., 1123 Windsor
1948 Horton, William Hanson, 52 Filley
1940 Kelley, Newell Raymond, 101 Palisade Ave.
1930 MacCready, William Harold, 38 Elm
1939 Monacella, John Manilla, 22 Elm
1947 Poirier, Theophane M., 26 Maple
1924 Pratt, Aaron Paul, 253 Broad
1950 Silliman, Warren B., 26 Prospect

SOUTH WINDSOR

1905 Starr, Robert Sythoff, Box 15

POQUONOCK

1947 Pomeroy, William Henry, 1852 Poquonock Ave.

WINDSOR LOCKS

1937 Coyle, Bruce James, 2 Chestnut
1952 Eilbergas, Michael, 110 Main
1948 Mullaney, Thomas Patrick, Jr., 29 North Main

OUT OF COUNTY

1950 Atwood, Albert Sterling, 400 Prospect, Torrington
1943 Barton, Preston Nicholas, Scott Rd., R. F. D. No. 2, Terryville
1946 Ciccarelli, Armanno William, Queens General Hospital, Jamaica, L. I., N. Y.
1939 Conlon, William Linas, Lahey Clinic, Boston, Mass.
1913 Costello, Henry Nicholas, Box 382, Madison
1951 Davey, Lycurgus Michael, 309 Edwards, New Haven
1951 Deyoe, Daniel Harden, Hood House, Univ. of New Hampshire, Durham, N. H.
1941 Dorian, George David, 4242 Campus Ave., San Diego, California
1947 Hanaghan, James Albert, Laurel Heights Sanatorium, Shelton
1950 Horgan, John Daniel, Chance-Vought Aircraft, Dallas, Texas
1934 'Horning, Benjamin Graham, W. W. Kellogg Foundation, Battle Creek, Michigan
1949 'Lonsdale, Henry George, V. A. Hospital, Fort Roots, North Little Rock, Arkansas
1947 Lyon, Harold P., Firestone Plantations Co., Harkel, Liberia, West Africa
1928 Mahoney, Daniel F. C., 729 South Buena Vista, Redlands, Calif.
1934 McLean, John Joseph, P. O. Box 881, Melbourne, Florida
1929 Morse, Lyman Rogers, R. R. 7, Kingston, Ontario, Canada
1939 'Moxness, Bennie Arthur, Surgeon General's Office, Hq. USAF, Washington, D. C.
1939 Murphy, Thomas Denis, 89 Appleton, Lowell, Mass.
1942 O'Brien, Henry Rust, U.S.P.H.S., Washington, D. C.
1921 Park, Paul Archibald, 411 Crestwood Rd., Fairfield
1923 Pendleton, Ernest Raymond, Granville Rd., Westfield, Mass.
1947 Plachta, Aaron, 105th and 5th Ave., New York, N. Y.

1951 Pond, Melbourne Jabez, 819 East Illinois, Kirksville, Missouri
1930 Pullen, Richard Woollard, 16th Field Hospital, APO 696, c/o Postmaster, New York
1902 Purinton, Charles Oscar, New Hartford
1949 Quimby, Robert Logan, Liberty Mutual Insurance Co., Boston, Mass.
1916 Simonton, Frank F., 634 W. Clivedon, Philadelphia, Pa.
1936 Stevenson, William Robb, N. Y. Polyclinic Medical School and Hospital, New York, N. Y.
1950 Storer, Daniel Phinney, Pratt Diagnostic Clinic, Harrison Ave., Boston, Mass.
1937 Tait, Arthur Alfred, 919 2nd Street S., Moorhead, Minn.
1923 Walker, William Hastings, P. O. Box 305, Newtown

Litchfield County Association

President: Thomas J. Danaher, 106 Litchfield St., Torrington
Vice-President: Royal A. Meyers, 162 Main St., Watertown
Secretary-Treasurer: John F. Kilgus, 119 Capitol Ave., Hartford
Councilor: W. Bradford Walker, Cornwall
Alternate Councilor: Frank D. Ursone, Greenwoods Rd., Norfolk

Annual Meeting, Fourth Tuesday in April
Semi-Annual Meeting, First Tuesday in October

CORNWALL

1922 Walker, Wilmarth Bradford

Cornwall Bridge

1931 Evarts, Josephine, Warren Rd.

Falls Village

1949 Meister, Louis Frederick, Dugway Rd.

HARWINTON

1906 Griswold, Maude Taylor

KENT

1951 Crohn, Edward Burrill, Main
1946 Greiner, George Frederick, Kent School
1947 Grendon, David Arthur, Lane

LITCHFIELD

1946 Dautrich, Albert William, West
1910 Turkington, Charles Henry, On-the-Green
1939 Warner, Charles Norton, Jr., North
1936 Wray, Edward Holloway, Jr., North

NEW HARTFORD

1942 Markwald, Heinz Wolfgang, Steele Rd.

NEW MILFORD

1949 Baird, Robert Desmond, Twin Pines
1951 Day, Rupert S., 8 Whittlesey Ave.
1939 LaTaif, C. George, 20 Bridge
1951 Miller, Robert Murdoch, Park Lane
1938 Stevens, Howard Granson
1947 Street, John M., 10 Aspetuck Ave.
1949 Wolfe, Leroy S., R. F. D. No. 2

NORFOLK

1937 Barstow, Richard Iddings, The Village Green
1934 Ursone, Frank Domenico, Greenwoods Rd.

NORTH CANAAN

Canaan

1929 Adam, Forbes Sampson
1946 Bornemann, Carl, Main
1935 Elliott, John Richard
1938 Sellew, Robert Cowan, Jr.

PLEASANT VALLEY

1950 Sherman, Hope

PLYMOUTH

Terryville

1951 Coral, Mark, 63 Main
1913 Lawton, Richard John, 9 North Main
1939 Wilcox, Lloyd Mather, 140 Main

SALISBURY

1945 Brewer, Alfred Edwin
1946 Combes, J. DeRaismes

Lakeville

1943 Mackay, William D.
1923 Peterson, Clark Kimball
1936 Wieler, Harry Julius, Hotchkiss School

SHARON

1949 Beattie, Guila Frances, Sharon Clinic
1949 Fisher, Robert Lownds, Sharon Clinic
1948 Fowler, George A., Sharon Clinic
1947 Gevalt, Frederick C., Jr., Sharon Clinic
1942 Gudernatch, Gaert Steuerwald
1949 Haydock, George Guest, Sharon Clinic
1947 Linder, James H., Gay
1947 Noble, Robert P., Sharon Clinic

THOMASTON

1946 Conklin, Clifford T., Jr., 16 Grand
1903 Hazen, Robert, 45 Union
1947 Samson, Daniel P., 147 Elm
1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

1946 Adams, Arthur John, Charlotte Hungerford Hospital
1948 Bisharat, Maurice H., 24 Church
1946 Blinkoff, Jack J., 5 Water
1946 Buckley, John Littlefield, 19 Mason
1950 Canniff, James Charles, 51 Main
1946 Chait, Sidney, 106 Litchfield
1950 Christine, Barbara Weed, 24 Mason
1950 Conforti, Victor Patrick, 400 Prospect
1930 Danaher, Thomas Joseph, 106 Litchfield
1938 Dobbs, William G. H., 24 Church
1946 Fabro, J. Alfred, 199 Main
1935 Garston, Louis Edward, 49 Main
1931 Giobbe, Michael Edward, 355 Prospect
1936 Goldberg, Isadore Solomon, 24 Church
1908 Hanchett, Harry Bigelow, 51 Main
1941 Hubert, Gilbert Richard, 19 Mason
1943 Humpage, Norbert W., 19 Mason
1949 Huvelle, Camille Henry, 241 Main
1951 Joseph, Clifford, 342 Main
1947 Katzin, Benjamin, 106 Litchfield
1949 Kennedy, Sidney Robinson, Jr., 241 Main
1938 Kott, Joseph Henry, 18 Pearl
1936 Lo Russo, Domenico Leonardo, 40 Main
1951 Lovallo, Frank, 382 Prospect
1950 Lyons, William Bernard, Charlotte Hungerford Hospital

1942 Mitchell, Gerald Vincent, 51 Main
1938 Murcko, William John, 24 East Main
1923 Oelschlegel, Herbert Charles, 355 Prospect
1942 Opper, Lincoln, Charlotte Hungerford Hospital
1938 Orlowski, Andrew Williams, 19 Mason
1923 Polito, Frank Leonard, 24 Church
1942 Riendeau, Fernand Maurice, 30 Mason
1942 Riendeau, Pauline Laure, 30 Mason
1949 Robertson, Alexander Rocke, 106 Litchfield
1932 Samponaro, Nicholas, 241 Main
1936 Sutherland, Francis Alexander, 24 Mason
1917 Thomson, Thomas Leonard, 24 Mason
1898 Wadhams, Sanford Hosea, 908 Main
1942 Wallach, Gert M. K., 91 Church
1917 Weed, Floyd Albert, 199 Main
1949 Welch, Winthrop Sherwood, 24 Mason

WASHINGTON

1946 Simonds, John Rolf
1908 Wersebe, Frederic William

WATERTOWN

1946 Caney, Wilbur Hinds, 429 Main
1949 Dickinson, Meredith Moore, 429 Main
1951 Goerner, Jessamine Roberta, 429 Main
1946 Louderbough, Henry, 313 Main
1897 Loveland, Ernest Kilborn, 48 North
1936 Myers, Royal Abbott, 162 Main
1919 Reade, Edwin Godwin, P. O. Box 226

WINCHESTER
WINSTED

1938 Baker, Philip George, 26 Elm
1936 Cornelio, Francis Joseph, 153 Main
1950 Downie, G. Robert, 64 Main
1937 Gallo, Francis, 442 Main
1936 Levy, Aaron, 26 Elm
1947 Reidy, Joseph Carey, 350 Main
1950 Reidy, Maurice Joseph, Jr., 350 Main
1922 Sanderson, Roy Voter, 518 Main
1947 Smith, James Thomas, 64 Main

WOODBURY

1948 Cushman, George Lester, North Woodbury
1944 Gillette, Arthur Taylor, Main

OUT OF COUNTY

1947 Blaine, Graham Burt, Jr., Sergeant, Stockbridge, Mass.
1936 Cleary, Harold John, 18 Central Ave., Waterbury
1942 Downs, Elinor Fosdick, 4 The High Rd., Bronxville New York
1927 Jackson, Arthur Hartt, 195 Grove, Waterbury
1917 Kennedy, William Clement, 139 Broad, Middletown
1935 Kilgus, John Frank, Jr., 119 Capitol Ave., Hartford
1949 Morrow, Howard Stephen, 345 Main, Danbury
1881 Platt, William Logan, State Hospital, Newtown

Middlesex County Association

President: WILLIAM J. TATE, Elm St., Deep River
Vice-President: NORMAN H. GARDNER, 43 Main St., East Hampton
Secretary: CHRISTIE E. MCLEOD, 28 Crescent St., Middletown
Councilor: F. ERWIN TRACY, 164 Court St., Middletown
Alternate Councilor: WILLARD E. BUCKLEY, 28 Crescent St., Middletown

Annual Meeting, Second Thursday in April
Semi-Annual Meeting, Second Thursday in October

CENTERBROOK

1947 Crawford, George

CHESTER

1941 Callender, Eugene Frederick, Drawer F
1935 Lieberman, David Leonard, West Main
1950 Smith, Vera La Misha, Main

CLINTON

1951 Hall, Mary Nettleton, 15 Liberty
1937 Rindge, Norman Pember, 20 Commerce

CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall
1934 Couch, Mildred Warden, Cromwell Hall
1940 Grant, Richard Francis, 145 Main
1928 Nelson, Walter Nathaniel, 76 Main
1925 Pierson, Emily Miller, 107 Main

DEEP RIVER

1939 Lobb, Russell Albert, 131 Main
1932 Tate, William James, Elm
1951 Ziegra, Sumner Root, 7 Elm

DURHAM

1951 Korn, Francis Edwin, Main

EAST HADDAM

1935 Horsefield, Thomas Earl, P. O. Box 40

EAST HAMPTON

1921 Felt, Paul Revere, R. F. D. No. 1
1936 Gardner, Norman Homer, 43 Main
1924 Holley, Erving, R. D. No. 1
1934 Soreff, Louis, 15 Main

ESSEX

1942 Ames, William Gard
1903 Bradeen, Frederick Barton, P. O. Box No. 221
1949 Harris, Augustus Ludlow, 60 Main
1952 Higgins, Victor William, Westbrook Rd.
1948 James, Walter Raymond, New City

HIGGANUM

1937 Calhoun, Hazen Albert, Jr.

MIDDLEFIELD

1947 Smith, Harold Ellsworth
1950 Trent, Sophie Clara, Box 62, Middlefield

MIDDLETOWN

1942 Alexander, Stanley Joseph, 516 Main
1950 Ayers, Conrad Marvin, 51 Broad
1951 Bauer, William Frederick, Jr., 119 Main
1933 Beauchemin, Joseph Adelard, Connecticut State Hospital
1951 Brown, Anna Conway, Connecticut State Hospital
1941 Buckley, Willard Emrich, Middlesex Hospital
1951 Cary, James Martin, 426 Ridge Rd.
1926 Chase, Carl Clarence, 121 Main
1928 Compson, Florence Eberly Mentzer, P. O. Box 715
1924 Craig, George Mansfield, 96 South Main
1942 Crampton, Clair Beebe, 96 South Main
1933 Fekety, Stephen Henry, 675 Main

1900 Fisher, Jessie Weston, 8 MacDonough Pl.
1927 Frank, Harry Selig, 144 Washington
1927 Grower, Julius Harry, 164 Court
1920 Harvey, Carl Clifford, 119 Main
1948 Harvey, Sanford W., 119 Main
1948 Harwood, Clarence W., 111 College
1951 Hough, Paul S., Box 361
1924 Joyce, William Michael, 121 Main
1946 Knight, Harry Charles, 33 Pleasant
1948 Korab, John Joseph, 66 South Main
1928 LaBella, Louis Oronato, 612 Main
1942 Lindsay, Marie Strom, Connecticut State Hospital
1925 Loffredo, Louis, 77 Crescent
1929 Magnano, Joseph, 100 Broad
1948 Marks, Bertram Eliah, Dept. of Health
1940 McLeod, Christie Ellen, 28 Crescent
1934 Minor, Lloyd Wesley, 119 Main
1896 Murphy, James, 101 Broad
1939 Palmieri, Mario Lorenzo, 54 Broad
1928 Piasta, Peter Ferdinand, 145 South Main
1952 Prescod, Horace Joffre, Connecticut State Hospital
1943 Rafkind, Abraham Benjamin, 108 Main
1934 Roccapriore, Benjamin Anthony, 287 Washington Ter.
1926 Russman, Charles, Connecticut State Hospital
1948 Santiccioli, Aldo Bruno, Connecticut State Hospital
1933 Schwartz, Philip Edward, 33 Pleasant
1945 Shenker, Benjamin Morton, 250 Main
1940 Sherwood, Henry, 516 Main
1929 Speight, Harold Edmund, 70 Crescent
1924 Sweet, Alfred Norton, 164 Court
1949 Thomson, Archibald Wilson, Jr., 96 South Main
1946 Thumim, Mark, 121 Main
1947 Toll, Nina, Connecticut State Hospital
1933 Tracy, F. Erwin, 164 Court
1942 Vinci, Vincent John, 70 Crescent
1934 Waterman, Chester, 119 Main
1933 Whiting, Harry St. John, Connecticut State Hospital
1922 Wrang, William Emil, 296 Main
1944 Yerbury, Edgar C., Connecticut State Hospital
1948 Yu, Poe-Eng, Connecticut State Hospital

MOODUS

1946 Berwick, Philip

OLD SAYBROOK

1949 Egan, John Robert, Old Boston Post Rd.
1934 Greenberg, Aaron, Main
1946 Saunders, George Robert, P. O. Box 92

PORTLAND

1948 Baker, Asher Lael, 25 Marlborough
1951 Blakeslee, Malcolm Ray, 25 Marlborough
1947 Epstein, Joseph I., 309 Main
1947 Longo, Americo Domenico, 344 Main
1941 Ryan, V. Gerard, 25 Marlborough

OUT OF COUNTY

1944 Bixby, Harriet, Mansfield Training School, Mansfield Depot
1905 Granniss, Irwin, Northford
1944 Katzenstein, Rolf Ewald, Meriden Hospital, Meriden
1948 Kidney, James J., Wm. Roche Hospital, Toledo, Ohio
1904 Kingman, James Henry, 96 Everit, New Haven
1948 Marks, Bertram Eliah, Dept. of Health, Pueblo, Colorado
1938 Prout, Edgar Bacon, 98 Garden, Hartford

New Haven County Association

President: Israel S. Otis, 165 West Main St., Meriden
Vice-President: Christopher E. Dwyer, 18 Pine St., Waterbury
Secretary: Samuel Spinner, 85 Trumbull St., New Haven
Councilor: Courtney C. Bishop, 33 Whitney Ave., New Haven
Alternate Councilor: Walter I. Russell, 139 Alston Ave., New Haven
Business Office: 364 Whitney Ave., New Haven
Annual Meeting, Fourth Thursday in March
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

1916 Aaronson, Michael S., 190 Main
1937 Alu, Anthony F., 290 Main
1935 Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John Joseph, 178 Main
1946 Galen, Jack Harris, 261 Main
1946 Haddad, Fred Melad, 156 Main
1938 Ignace, Stephen J., 126 Main
1943 Lencz, Erwin D., 50 Main
1932 Renehan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1947 Szanton, Victor Leo, 259 Main

BRANFORD

1934 Blanchard, Dana Lincoln, 87 Main
1931 Bodie, William Joseph, 256 Main
1940 Carpinella, Michael Joseph, 48 Kirkham
1917 Gaylord, Charles William, 93 South Main
1929 Levy, Nathan, 140 Montowese
1916 McQueen, Arthur Samuel, 187 Montowese
1946 Rosenthal, Richard Louis, 87 Main

Pine Orchard

1943 Calabresi, Massimo, Crescent Bluff Ave.

CHESHIRE

1949 Dayton, Charles John, Maple Ave.
1923 Moore, Wilbur John, Maple Ave.
1940 Neff, William Everett, Jr., Main
1939 Oxnard, Edward Warren, Maple Ave.

DERBY

1927 Burns, George Dewey, 42 Seymour Ave.
1940 D'Ambruoso, Dominic Charles, 46 Atwater
1944 Davis, Donald Alan, 38 Elizabeth
1940 Dreher, Samuel Meyers, 282 Main
1944 Narowski, John Joseph, 17 Elizabeth
1910 Parlato, Michael Antonio, 270 Elizabeth
1925 Rentsch, Samuel Burton, 61 Seymour Ave.
1940 Stygar, Joseph Stanislaus, 272 Main
1910 Treat, William Howard, 166 Minerva

EAST HAVEN

1940 Balletto, Vincent, 535 Thompson Ave.
1937 Beckwith, Donald MacFarlane, 239 Main
1940 Grenon, Ovilda Arzidas, 265 Main
1924 Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

1951 Adams, Elisabeth C., 1 Whitfield
1951 Herr, Herbert Harvey, West Lake
1941 McGuire, Frank James, 29 Whitfield

HAMDEN

1952 Albis, Michael Daniel, 1270 Dixwell Ave.
1947 Carbone, William Charles, 1428 Dixwell Ave.
1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
1947 Elgosin, Richard B., 2440 Whitney Ave.
1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
1944 Fischer, Alexander, 18 Helen
1948 Greenhouse, H. Robert, 1214 Dixwell Ave.
1943 James, George R., 25 Central Ave.
1942 McKeon, James Joseph, 1828 Dixwell Ave.
1938 Parente, Leonard, 126 Church
1903 Rand, Richard Foster, 91 Churchill Rd.
1946 Slater, Daniel, 1100 Dixwell Ave.
1927 Slater, Morris, 1100 Dixwell Ave.
1947 Trifari, Leopold Mariano, 1087 Whitney Ave.
1949 Wyatt, Herbert, 1696 Whitney Ave.
1950 Zale, Charles, 2331 Whitney Ave.

MADISON

1946 Birnbaum, Hyman Bunge
1951 Douglass, Wallace Capron, Steven's Inn
1943 Rindge, Mila Elisabeth, Boston Post Rd.
1908 Rindge, Milo Pember, Boston Post Rd.
1948 Smith, Ellsworth Johnson, Scotland Ave.

MERIDEN

1934 Affinito, Thomas, 128 West Main
1950 Allen, Benjamin Israel, 219 West Main
1949 Andrus, Daniel Sylvester, Undercliff
1950 Badner, Donald Harold, 219 West Main
1951 Beaty, Harold W., 118 Colony
1948 Beloff, Jerome Seymour, 213 East Main
1946 Boguniecki, Stanley Joseph, 114 East Main
1950 Broady, Harold, 219 West Main
1945 Brown, Marion R. Snyder, 120 Cook Ave.
1947 Brown, Patrick Neely, 120 Cook Ave.
1948 Burbank, John, Meriden Hospital
1928 Caplan, Henry, 219 West Main
1939 Caplan, Max, 219 West Main
1937 Carey, William Clark, 61 Colony
1946 Clarke, Winthrop Irving, 35 Colony
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ East Main
1949 Cusnir, Marion, 97 East Main
1939 de La Vergne, Paul Mason, Undercliff
1927 DeRosa, Sylvester Frank, 29 Cook Ave.
1948 Dickinson, George Herbert, 199 West Main
1946 DiGiandomenico, Albert Theodore, 63 Yale
1950 Flynn, Charles Thomas, Jr., 147 West Main
1948 Flynn, John Benedict, 118 Colony
1930 Foster, Edward Wendell, 147 West Main
1940 Fox, George Graham, 147 West Main
1921 Gibson, Cole Blease, Undercliff
1946 Giddings, James Curtis, 219 West Main
1947 Giuffrida, Francis, 118 Colony
1946 Glike, Frederick Philip, 69 Colony
1929 Hall, William Edward, 147 West Main
1941 Katz, Irving, 42½ East Main
1944 Krochmal, Henry, 455 Broad
1939 L'Heureux, Jerome Arthur, 455 Broad
1934 Lirot, Stephen Leo Robert, 147 West Main
1907 Lockwood, Howard DeForest, 248 East Main
1946 Lohrmann, Walter, Undercliff
1934 Mekrut, Joseph Anthony, 68 East Main
1928 Mills, Bernard Litchfield, 94 East Main
1934 Misuk, Joseph Francis, 428 Broad
1913 Murdock, Thomas Patrick, 147 West Main
1921 Otis, Fessenden Newport, 165 West Main
1920 Otis, Israel Sabine, 165 West Main
1932 Pennington, Harry Freeman, 455 Broad
1931 Pierson, Louis A., 199 West Main
1916 Quinlan, Raymond Vincent, 5 State
1947 Robb, Samuel Aloysius, 69 East Main
1944 Ryan, Allan James, 147 West Main
1913 Smith, David Parker, 199 West Main
1942 Smith, Edward Rice, 69 Colony
1934 Strickland, Harold, 128 West Main
1945 Taylor, Hoyt Chase, 213 East Main
1931 Thompson, Lawrence Everett, Undercliff
1921 Tower, Arthur Augustus, 147 West Main
1952 Turcotte, Maurice Raymond, 118 Colony
1947 Vadasz, Edmond, Connecticut School for Boys
1940 Van Leuvan, James Sipple, 61 Colony
1946 White, Howard Thomas, Undercliff
1921 Wilson, James Alfred, 61 Colony

MILFORD

1938 Barney, Walter Edward, 186 Broad
1949 Buckman, Robert Francis, 157 Gulf
1913 Fischer, William John Henry, 3 Lafayette
1929 Geib, Henry Albert, Zion Hill Rd.
1946 Higgins, Harold Gerard, 38 West Main
1951 Kussner, Shirley Frances, 132 New Haven Ave.
1944 Langner, Helen P., 1 Shipyard Lane
1939 Lee, Frank Nelson, 56 Broad
1946 Lipkoff, Clarence Joseph, 158 Broad
1946 Marinoff, Philip A., 158 Broad
1946 Parrella, Gioacchino, 188 Broad
1946 Rosenthal, Benjamin B., 26 Lafayette
1948 Shea, Joseph Patrick, Jr., 15 Broadway
1951 Spencer, Leon O., 97 North
1933 Stetson, Harry Warren, 114 Broad
1946 Timm, Alexander Berthold, Jr., 36 West Main
1940 Viola, Carl Philip, 26 Cherry
1947 Weston, Robert Alphaeus, Jr., 114 Broad

Devon

1934 Andrus, Oliver Burton, 32 Daytona Ave.
1941 Lee, John Ranks, 21 Colonial
1947 Malone, Robert Francis, 21 Rivercliff Dr.

NAUGATUCK

1941 Bluestone, David Harrison, 9 Terrace Ave.
1923 Hill, William Edward, 150 Meadow
1940 Kennedy, Charles Stephen, 14 Hillside Ave.
1938 Reilly, Walter John, 170 Meadow
1937 Towne, Nehemiah Alvarado, 297 Church
1940 Tylec, Leo Louis, 156 Meadow
1944 Weile, Fred William, 270 Church
1926 Williams, Edward Everett, 269 Church

NEW HAVEN

1950 Albis, Francis Joseph, 35 Main, the Annex
1945 Albom, Jack Jonathan, 43 Trumbull
1921 Alderman, Irving Saunders, 38 Trumbull
1925 Allen, Edward Pratt, 265 Church
1902 Allen, Millard Filmore, 65 Dixwell Ave.
1947 Allinson, M. J. Carl, 133 West Park Ave.
1932 Amatruda, Frank Gabriel, 542 Chapel
1929 Appell, Harold Seymour, 79 Trumbull
1930 Arnold, H. Bruno, 1442 Chapel
1951 Baer, Irving Nathan, 135 Whitney Ave.
1952 Banfield, William Gethin, 310 Cedar
1920 Barker, Creighton, 160 St. Ronan
1896 Bartlett, Charles Joseph, 183 Bishop
1936 Bassin, Alexander Lewis, 255 Bradley

1930 Batelli, Clement Francis, 161 Church
1925 Battista, Anthony William, 111 Osborn Ave.
1947 Beauchamp, Maurice Flavian, 59 Trumbull
1926 Behan, Edmund Joseph, 1370 Chapel
1931 Benedict, Mary Kendrick, 548 Orange
1940 Berlowe, Max Llewellyn, 315 Whitney Ave.
1920 Berman, Harry Loring, 1142 Chapel
1944 Berneike, Robert R., 412 Orange
1940 Biondi, Benedict, 120 Blatchley Ave.
1939 Bishop, Courtney Craig, 33 Whitney Ave.
1951 Black, Samuel Paul, 789 Howard Ave.
1907 Blake, Eugene Maurice, 303 Whitney Ave.
1927 Blodinger, Israel Edward, 291 Whitney Ave.
1950 Bloomer, William Ernest, 789 Howard Ave.
1911 Boardman, Albertus Kellogg, 441 Forbes Ave.
1926 Bodie, John Allen, 222 Edwards
1951 Brand, Elliott Saul, 146 Sherman Ave.
1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.
1935 Brody, Bernard Stephen, 235 Bishop
1949 Brody, Eugene Bloor, 58 Trumbull
1946 Bruno, Joseph Julius, 505 Whalley Ave.
1930 Bumstead, John Henry, 309 Edwards
1942 Bunting, Henry, 310 Cedar
1934 Canfield, Norton, 175 St. Ronan
1928 Capecelatro, Alfonso, 142 Columbus Ave.
1916 Carelli, Genesis Frank, 27 Elm
1949 Carter, Max George, 614 Orange
1946 Castiglione, Frank Michael, 245 Edwards
1948 Catalan, John Ovey, 198 Dixwell Ave.
1932 Celentano, Luca Eugene Humbert, 115 Howe
1946 Cerrone, Luke John, 67 Chapel
1946 Cheney, Charles Brooker, 64 Trumbull
1949 Chernoff, Hyman M., 1142 Chapel
1947 Cipriano, Anthony Pasquale, 451 Orange
1934 Claiborn, Louis Nixon, 255 Whitney Ave.
1937 Clark, Mildred Helen, 244 Sherman Ave.
1938 Clarke, Clement Cobb, 240 Bradley
1946 Clement, David Hale, 240 Bradley
1950 Clifton, Eugene Everett, 789 Howard Ave.
1935 Climo, Samuel, 291 Whitney Ave.
1923 Cobey, James Francis, 1210 Chapel
1925 Cofrances, Louis William, 190 Winthrop Ave.
1950 Cohart, Edward M., 310 Cedar
1942 Cohen, Louis Harold, 40 Trumbull
1924 Cohen, William, 1195 Chapel
1951 Colbert, James William, 333 Cedar
1951 Coleman, Jules Victor, 135 Whitney Ave.
1917 Collins, William Francis, 66 Trumbull
1921 Colwell, Howard Spencer, 309 Edwards
1914 Comfort, Charles Williams, Jr., 27 Elm
1931 Connolly, Arthur James, 59 Trumbull
1947 Connor, Gervase Joseph, 333 Crown
1914 Conte, Harry Albert, 38 Trumbull
1939 Conte, Mario Gero, 175 Grand Ave.
1943 Conway, David Francis, Jr., 148 Sherman Ave.
1931 Corradino, Charles Louis, 516 Howard Ave.
1937 Craighill, Margaret D., 340 Whitney Ave.
1936 Culotta, Charles Salvatore, 291 Whitney Ave.
1943 Curtis, William Boyd, 432 Temple
1952 Cusanelli, Gabriel Nicholas, 174 Bradley
1940 Cutler, Herman Shepard, 1308 Chapel
1941 D'Alessio, Charles Magno, 1442 Chapel
1924 Dallas, Marion, 248 Bradley
1943 D'Amico, Joseph, 197 James
1935 D'Amico, Michael, 309 Edwards
1934 Darrow, Daniel Cady, 789 Howard Ave.
1939 Davis, Jachin Boaz, 364 Oak
1920 Dayton, Arthur Bliss, 309 Edwards
1942 de Forest, Gideon Knapp, 309 Edwards
1951 Delgrego, Arthur L., 459 Orange
1951 D'Elia, Pierino Francis, 27 Elm
1920 Deming, C. Kenneth, 66 Trumbull
1922 Deming, Clyde Leroy, 789 Howard Ave.
1925 Dennehy, William James, 158 Whitney Ave.
1935 D'Esopo, Joseph Nicholas, 614 Orange
1943 de Suto-Nagy, Ilona Krasso, 158 Whitney Ave.
1922 Duffy, William Core, 608 Whitney Ave.
1948 Dwyer, Hugh Leo, Jr., 309 Edwards
1943 Epstein, Charles J., 31 Dwight
1952 Erba, Salvatore Michael, 245 Edwards
1923 Errico, Louis, 26 Elm
1951 Erslev, Allan Jacob, 789 Howard Ave.
1946 Etkind, Meyer George, 1546 Chapel
1950 Evans, Alfred Spring, 333 Cedar
1925 Evans, Theodore Schlosser, 59 Trumbull
1943 Eveleth, Malcolm Standish, 64 Trumbull
1950 Fasanella, Rocko Michael, Grace-New Haven Hospital
1951 Filer, Harry Lambert, Jr., 129 Whitney Ave.
1942 Fiorito, Joseph Anthony, 59 Trumbull
1929 Fiskio, Peter William, 215 Whitney Ave.
1951 Fitts, Fernald Churchill, P. O. Drawer 906
1948 Fitzpatrick, Eugene Joseph, 111 Sherman Ave.
1945 FitzSimmons, Edmund Francis, 19 Howe
1914 Flynn, Charles Thomas, 41 Trumbull
1929 Flynn, Harold Aloysius, 464 Dixwell Ave.
1951 Foord, Edward, 789 Howard Ave.
1888 Foote, Charles Jenkins, 230 Willow
1907 Ford, Alice Porter, 1400 Chapel
1950 Forman, Joseph Bernard, 850 Howard Ave.
1929 Foster, Lewis Chandler, 309 Edwards
1924 Freedman, Barnett Philip, 322 George
1951 Freedman, Lawrence Zelic, 333 Cedar
1951 Freedman, Morris, 1142 Chapel
1936 Freeman, David, 210 Prospect
1940 Friedman, Irving, 850 Howard Ave.
1937 Fry, Clements Collard, 109 College
1941 Fuldner, Russell Victor, 85 Trumbull
1940 Garofalo, Mario Louis, 27 Elm
1938 Geiger, Arthur Joseph, 309 Edwards
1945 Gencarelli, Alphonse Frank, 85 Trumbull
1937 Gentile, Angelo Louis, 291 Whitney Ave.
1937 German, William John, 789 Howard Ave.
1947 Gesell, Arnold, 185 Edwards
1923 Gettings, James Augustus, 209 Whalley Ave.
1924 Giamarino, Henry James, 291 Whitney Ave.
1951 Gibson, Fred, 315 Whitney Ave.
1951 Gill, Merton Max, 60 Wall
1943 Gillson, Reginald Eric, 255 Bradley
1946 Gilmer, Roy Jones, 259 Dixwell Ave.
1942 Gilmore, Helen Richter, 19 Edgehill Rd.
1947 Glaser, William, 1098 Chapel
1926 Glazer, Morris, 1172 Chapel
1949 Glenn, William W. L., 798 Howard Ave.
1941 Godfried, Milton Simons, 85 Trumbull
1947 Goetsch, John Black, 412 Orange
1910 Goldberg, Samuel James, 43 Trumbull
1941 Goldberg, Samuel James, Jr., 43 Trumbull
1912 Goldman, George, 201 Park
1927 Goldstein, Morris, 451 George
1951 Golia, Ulysses Vitalio, 27 Elm
1947 Gompertz, Michael Louis, 43 Trumbull
1950 Goodyer, Allan Victor, 789 Howard Ave.
1941 Grady, Joseph Francis, 265 Church
1941 Granoff, Morris Aaron, 327 Whalley Ave.
1950 Gray, Frank Davis, Jr., 789 Howard Ave.
1950 Gray, Freida G., 333 Cedar
1948 Green, Fred Chiles, 25 Charles
1947 Green, Robert Holt, 789 Howard Ave.

1924 Greenhouse, Barnett, 129 Whitney Ave.
1941 Grillo, Vincent James, 85 Trumbull
1927 Groark, Joseph Anthony, 145 Grand Ave.
1931 Grodin, Herman Wolmer, 840 Howard Ave.
1952 Grosskreutz, Doris C., 789 Howard Ave.
1939 Guida, Francis Paul, 87 Park
1949 Haley, John Carlin, 59 Trumbull
1947 Hampton, Louis J., 789 Howard Ave.
1936 Hankin, Morris Albert, 43 Trumbull
1947 Hanson, Millard Charles, 158 Whitney Ave.
1930 Harris, Benedict Richard, 315 Whitney Ave.
1937 Harris, Jesse Samuel, 239 Bradley
1931 Harrison, Elizabeth Ross, 255 Bradley
1935 Hart, James Clement, 820 Elm
1951 Hart, Robert Warren, 1308 Chapel
1920 Harvey, Samuel Clark, 211 Highland
1937 Hathaway, John Seabury, 109 College
1941 Heinemann, Martin, 210 Prospect
1916 Hendricks, Albert Ludwig, 26 Trumbull
1907 Henze, Carl William, 466 Orange
1942 Hersey, Thomas Francis, 291 Whitney Ave.
1937 Hess, Orvan Walter, 79 Trumbull
1930 Higgins, Joseph John, 74 Dwight
1922 Hillman, Maurice Manuel, 31 Howe
1916 Hirata, Isao, 1455 Chapel
1943 Hitchins, Clayton Stanley, 59 Trumbull
1943 Hodgkins, Charles Henry, 59 College
1924 Howard, Albert Joseph, 432 Whalley Ave.
1935 Howard, Marion Edith, 158 Whitney Ave.
1915 Hynes, Frederick Henry, 195 Church
1952 Igersheimer, Walter Wilhelm, 39 Argonne
1950 Ingenito, Gabriel Andrew, 181 Edwards
1936 Jackson, Edith Banfield, 789 Howard Ave.
1943 Jaffe, Samuel A., 235 Bishop
1948 Janzen, Arnold Herbert, 789 Howard Ave.
1927 Jenkins, Ralph Hathaway, Emergency Hospital, New Haven Railroad
1933 Johnson, Carl Edward, 364 Oak
1938 Jordan, Robert Hough, 64 Trumbull
1949 Joseph, Lester George, 175 Bishop
1946 Josephs, William Walter, 1172 Chapel
1944 Kartin, Bernard Leon, 39 Trumbull
1944 Katz, Harvey Warren, 256 Bradley
1951 Kausel, Harvey Weppler, 789 Howard Ave.
1951 Kazanjian, Norton Artin, 27 Elm
1949 Keller, Florence, 158 Whitney Ave.
1946 Kertesz, Johann, 45 Trumbull
1942 Kirby, Sam Bartholomew, 461 Humphrey
1951 Kirchner, John Albert, 789 Howard Ave.
1951 Kitchen, Benjamin Ford, Jr., 789 Howard Ave.
1938 Klatskin, Gerald, 107 Whitney Ave.
1928 Klebanoff, Harry Erwin, 1497 Chapel
1948 Klein, Harry, 432 Temple
1917 Kleiner, Simon Bretzfelder, 245 Edwards
1940 Koufman, William Bernard, 121 Whitney Ave.
1942 Krosnick, Gerald, 55 Park
1935 Krosnick, Morris Yale, 55 Park
1949 Kummer, Alfred John, 789 Howard Ave.
1937 Kushlan, Samuel Daniel, 303 Whitney Ave.
1948 Lach, Frank Edward, 181 Edwards
1949 LaFemina, Nicholas Francis, 548 Chapel
1940 Latimer, Marvin Luther, 129 Whitney Ave.
1936 Lavietes, Paul Harold, 442 Temple
1949 Lavorgna, Michael Henry, 146 Sherman Ave.
1915 Lear, Maxwell, 1172 Chapel
1948 Leavy, Stanley Arnold, 235 Bishop
1944 Lennox, Margaret Agnes, 333 Cedar
1943 Leonard, Marion, 158 Whitney Ave.
1923 Levin, Hyman Alexander, 1142 Chapel
1920 Levy, Daniel Frederick, 1288 Chapel
1948 Lewis, Herbert Daniel, 256 Bradley
1923 Lewis, Robert Morton, 52 Trumbull
1939 Licbow, Averill Abraham, 310 Cedar
1951 Lillian, Marvin, 789 Howard Ave.
1943 Lindskog, Gustaf Elmer, 789 Howard Ave.
1919 Little, Herman Clark, 303 Whitney Ave.
1927 Logan, William Joseph, 412 Whalley Ave.
1944 Lolli, Giorgio, 60 Bishop
1949 Lowenberg, Robert Ira, 245 Edwards
1942 Lowman, Robert Morris, 108 Livingston
1947 Lydon, Lawrence G. M., 45 Trumbull
1926 MacCready, Paul Beattie, 442 Temple
1949 Magyar, Steven Paul, 79 Trumbull
1949 Maiorano, Joseph Francis, Jr., 1403 Chapel
1946 Markoff, Abraham, 43 Trumbull
1946 Marshak, Irving Jacob, 1142 Chapel
1927 Marshall, Carter Lee, 1488 Chapel
1928 Marvin, Harold Myers, 303 Whitney Ave.
1921 Massa, Anthony Francis, 19 Howe
1931 Mastroianni, Luigi, 248 Bradley
1951 Matossian, Nerses Yacomb, 442 Temple
1925 Maurer, Lloyd Leslie, 41 Trumbull
1934 McAlenney, Paul Francis, Jr., 250 Edwards
1949 McDonnell, Robert Ralph, 235 Bishop
1947 Meigs, J. Wister, 310 Cedar
1940 Mendelsohn, William, 442 Temple
1916 Mendillo, Anthony Joseph, 45 Trumbull
1933 Mendillo, John Carleton Francis, 255 Bradley
1949 Michel, Lawrence Irwin, 451 George
1952 Micheels, Louis Joseph, 333 Cedar
1938 Mignone, Joseph, 129 Whitney Ave.
1942 Millen, Samuel Robert, 545 Dixwell Ave.
1942 Mogil, Marvin, 59 College
1930 Mongillo, Frank, 5 Elm
1942 Moore, Donald Bernard, 588 Howard Ave.
1946 Moss, Harry George, 646 Dixwell Ave.
1943 Mott, Frederick Edward, 38 Trumbull
1922 Musselman, Luther Kyner, 39 Trumbull
1944 Mylon, Ernst, 358 Central Ave.
1921 Nahum, Louis Herman, 1142 Chapel
1940 Nesbit, Robert Raymond, 1442 Chapel
1946 Newman, Harry Rudolph, 1172 Chapel
1922 Newman, Joseph Thomas, 150 Shelton Ave.
1935 Newman, Richard, 158 Whitney Ave.
1914 Nichols, Ralph Wilbur, 57 Trumbull
1932 Nodelman, Jacob, 26 Elm
1947 O'Brasky, George Harry, 1142 Chapel
1933 O'Brasky, Louis, 1172 Chapel
1920 O'Brien, William Henry Joseph, 265 Church
1950 O'Connell, Edward Bernard, 1210 Chapel
1922 O'Connor, Denis Stanislaus, 241 Edwards
1931 Oughterson, Ashley Webster, 158 Whitney Ave.
1936 Palmieri, Michael Walter, 556 Howard Ave.
1949 Pantaleo, Carl Vito, 291 Whitney Ave.
1951 Parisi, Anthony Joseph, 1187 Chapel
1951 Parkinson, Jessie Elizabeth, 90 Greenwood
1946 Pasternak, Maxwell, 210 Prospect
1929 Paul, John Rodman, 789 Howard Ave.
1949 Peck, Dorothea Rodley, 789 Howard Ave.
1943 Pelliccia, Orlando, Jr., 525 Whitney Ave.
1940 Perham, William Sidney, 309 Edwards
1925 Peters, John Punnett, 789 Howard Ave.
1927 Petrelli, Joseph, 455 Orange
1946 Petrillo, Charles, 87 Park
1923 Philipson, Samuel, 100 Whitney Ave.
1909 Phillips, Frank Lyman, 303 Whitney Ave.
1935 Piazza, George Joseph, 78 Orchard
1942 Piccolo, Pasquale A., 41 Trumbull

1931 Pinn, Abraham Samuel, 75 Sherman Ave.
1952 Pious, William Leon, 340 Whitney Ave.
1942 Pitegoff, Charles Haskell, 148 Sherman Ave.
1949 Plunkett, John P., 235 Bishop
1927 Poole, Allan King, 37 Trumbull
1938 Poverman, David, 67 Trumbull
1927 Powell, Wilson, 909 Whalley Ave.
1925 Powers, Grover Francis, 167 Armory
1934 Rademacher, Everett Stanley, 442 Temple
1949 Radowiecki, Micislaus Walter, 1305 State
1951 Redlich, Elsa Amalia, 60 Wall
1943 Redlich, Frederick Carl, 333 Cedar
1924 Riccitelli, Mariano Louis, 476 Howard Ave.
1946 Richards, William Raymond, 146 Sherman Ave.
1947 Riesman, John Penrose, 57 Trumbull
1938 Rilance, Arnold Boon, 614 Orange
1949 Riordan, William Darling, 245 Edwards
1951 Roberts, Bertram Horace, 333 Cedar
1929 Roberts, Frederick William, 158 Whitney Ave.
1951 Robinson, Franklin, 250 Edwards
1920 Rogers, Orville Forrest, 109 College
1929 Rogowski, Bernhard Albert, 75 Whitney Ave.
1941 Roth, Oscar, 42 Trumbull
1949 Roth, Stefanie Z., 42 Trumbull
1932 Rothschild, Morris Loeb, 315 Whitney Ave.
1941 Rozen, Alan Abraham, 113 Howe
1937 Rubin, George Alan, 1150 Chapel
1914 Russell, Thomas Hubbard, 57 Trumbull
1922 Russell, Walter Irving, 139 Alston Ave.
1920 Russo, Joseph Daniel, 255 Edwards
1921 Ryder, William Harold, 250 Edwards
1950 Sachs, Ernest, 333 Cedar
1933 Salinger, Robert, 309 Edwards
1944 Salter, William Thomas, 333 Cedar
1911 Scarbrough, Marvin McRae, 47 Trumbull
1948 Scholhamer, Charles Frederick, 116 Avon
1931 Scholl, Robert Frederick, 215 Whitney Ave.
1924 Scott, Clifton Russell, 215 Whitney Ave.
1920 Seabury, Robert Brewster, 58 Trumbull
1916 Segnalla, Ernest, 613 Chapel
1951 Senn, Milton J. E., 14 Davenport Ave.
1923 Serafin, Peter James, 809 State
1949 Shapiro, Robert, 1442 Chapel
1923 Shea, Michael Stephen, 500 Howard Ave.
1929 Shure, Abraham Lewis, 1184 Chapel
1950 Shutkin, Ned Manfred, 789 Howard Ave.
1947 Sigel, Harry, 85 Trumbull
1923 Silverberg, Samuel Joshua, 315 Whitney Ave.
1913 Skiff, Stuart Ernest, 1194 Chapel
1944 Smirnow, Max Ruskin, 1142 Chapel
1923 Smith, Charles Seaver, 59 College
1942 Smith, Frederick Francis, 84 Dixwell Ave.
1940 Smith, Norman Nathaniel, 291 Whitney Ave.
1946 Snoke, Albert Waldo, 789 Howard Ave.
1927 Snurkowski, Charles Vincent, 487 Orange
1947 Sohler, Theodore Paul, 167 Livingston
1951 Solnit, Albert Jay, 14 Davenport Ave.
1927 Sperandeo, Anthony, 441 Orange
1942 Spiegel, Charles Markle, 59 College
1939 Spinner, Samuel, 85 Trumbull
1951 Stainbrook, Edward John, 333 Cedar
1907 Standish, Frank Billings, 33 Morris Cove Rd.
1946 Stilson, Carter, 309 Edwards
1925 Stone, Emerson Law, 129 Whitney Ave.
1920 Strauss, Maurice Jacob, 41 Trumbull
1897 Sullivan, John Francis, 1346 Chapel
1923 Sullivan, Thomas Joseph, 495 Orange
1951 Swan, Bernard Robert, 291 Whitney Ave.
1946 Swift, William Everett, Jr., 333 Cedar
1946 Swirsky, Morgan Yale, 1204 Chapel
1946 Taffel, Max, 850 Howard Ave.
1915 Thoms, Herbert, 789 Howard Ave.
1911 Tileston, Wilder, 442 Temple
1947 Tortora, Frank, 386 Ferry
1949 Van Heuven, J. Alexander, 244 Edwards
1949 Varley, Ransom, 1187 Chapel
1942 Vegliante, Michael E., 174 Bradley
1896 Verdi, William Francis, 27 Elm
1943 Verstandig, Charles Coleman, 129 Whitney Ave.
1924 Vestal, Paul William, 79 Trumbull
1941 Vollero, Andrew, 619 Howard Ave.
1951 Wagenheim, Harry H., 109 College
1926 Wakeman, Edward Taylor, 240 Bradley
1945 Waldemar-Kertész, Johanna, 201 Park
1951 Waters, Levin Lyttleton, 310 Cedar
1919 Weil, Arthur, 291 Whitney Ave.
1950 Weiner, Joseph, 100 Whitney Ave.
1944 Welt, Louis Gordon, 789 Howard Ave.
1948 Wessel, Morris Arthur, 789 Howard Ave.
1952 Wexler, Henry, 340 Whitney Ave.
1951 White, Mary Louise, 789 Howard Ave.
1947 White, Robert Morris, 240 Bradley
1916 Whiting, Leonard Clark, 121 Whitney Ave.
1936 Wies, Frederick Albert, 255 Bradley
1941 Wilkinson, Arthur Gilbert, 111 Sherman Ave.
1950 Williams, Marshall Henry, Jr., 789 Howard Ave.
1931 Willner, Otto, 121 Whitney Ave.
1947 Wilson, Charles Christopher, 310 Cedar
1931 Wilson, William Rives, 255 Bradley
1947 Winer, Paul, 315 Whitney Ave.
1922 Winters, Sidney, 1175 Chapel
1895 Wurtenberg, William Charles, 445 St. Ronan
1920 Yudkin, Arthur Meyer, 257 Church
1942 Zaff, Fred, 135 Whitney Ave.
1947 Zagraniski, Raymond Joseph, 977 Whalley Ave.
1952 Zanes, Robert Parker, Jr., 59 Trumbull

NORTH HAVEN

1949 Bohan, Gunar Naib, 31 Broadway
1941 Cashman, Justin Laurence, Broadway
1943 Gillis, Grace Elaine, St. John
1924 Jack, John Louis, 1415 Ridge Rd.
1947 James, Mary Latimer, 1715 Hartford Turnpike
1913 Lang, William Peter, The Cedars
1951 Marsh, Elias Joseph, 25 Cooper Rd.
1940 Parrella, Louis Arnold, Trumbull Pl.
1923 Taylor, Sterling Price, Broadway and Post Rd.

ORANGE

1939 Boisvert, Paul Leo, Chestnut Ridge Rd.

OXFORD

1951 Gedeon, Philip Elias, R. F. D. No. 1, Box 274

SEYMOUR

1938 Chobian, Joseph Aloysius, 195 Main
1941 Harvey, Edward Regis, 119 Main
1946 Harvey, Edward Regis, Jr., 119 Main
1934 Rogol, Oscar, 135 Main

SOUTHBURY

1942 Deutsch, Joyce Victoria, Southbury Training School
1935 Yannet, Herman, Southbury Training School

WALLINGFORD

1943 Boyarsky, Harry Morton, 450 Center
1947 Boyd, Robert Booth, 176 North Main

1932 Breck, Charles Arthur, 176 North Main
1949 Breck, Richard William, 176 North Main
1929 Campbell, Sherburne, 270 Center
1930 Carrozella, John Christy, 35 South Main
1950 Dundee, John Chichester, Gaylord Farm
1942 Ferguson, James Fulton, Jr., 176 North Main
1942 Gushee, Edward Stockbridge, 187 North Main
1946 Konopka, Frank Joseph, 235 Center
1905 Lyman, David Russell, Gaylord Farm
1911 McGaughey, James David, 261 Center
1947 McGaughey, James David, III, 261 Center
1916 Morriss, W. Haviland, Gaylord Farm
1942 Murphy, Thomas Basil, 324 North Elm
1940 Pelz, Kurt, 26 South Main
1919 Sheehan, Mark Thomas, 245 Center
1931 Spignesi, John Theodore, 393 Center

WATERBURY

1924 Allen, Harry Everett, 30 Prospect
1929 Atkins, Samuel Maurice, 63 Central Ave.
1923 Audet, Charles Henry, 3 Second Ave.
1942 Backhus, Louis Charles, 604 Willow
1910 Barber, Walter Lewis, Jr., 102 Euclid Ave.
1949 Beauchamp, Lawrence Arthur, 89 Willow
1908 Bevans, Theodore Frank, 111 West Main
1931 Bizzozero, Orpheus Joseph, 59 Cooke
1950 Blank, Samuel, 64 Robbins
1951 Blansfield, Henry Nelson, 193 Grand
1942 Blau, Rudolf, 47 Cooke
1946 Bloomberg, Maxwell H., 53 Cooke
1939 Bonner, Robert Alexander, 51 West Main
1943 Bonner, Robert Alexander, Jr., 43 Central Ave.
1943 Bowen, Joseph John, Jr., 60 Cooke
1910 Brennan, Patrick Joseph, 135 West Main
1928 Brown, Abe Solomon, 58 Central Ave.
1940 Burke, Joseph Francis, 39 Central Ave.
1937 Burnham, Bernard Alfred, 65 Bank
1948 Cappelletti, A. Joseph, Waterbury Hospital
1945 Carpentieri, Anthony Louis, 18 Aetna
1941 Cole, Clarence Hummer, 111 West Main
1935 Collins, Joseph Osborn, 64 Robbins
1952 Cooper, Roger William, 300 West Main
1942 Coppeto, C. James, 220 East Main
1932 Corbett, Herbert John, 14 Central Ave.
1942 Coshak, Morris, 58 Holmes Ave.
1928 Cottiero, Thomas, 21 Cooke
1947 Cox, Marcus Edward St. Mary's Hospital
1928 Curran, Harold Joseph, 111 West Main
1951 Daly, Joseph Edmund, 111 West Main
1940 Damiani, Rudolph Andrea, 5 Cooke
1951 Davie, Robert N., 165 Grove
1942 DeCristoforo, Ralph, 291 North Main
1948 Devenis, Michael M., 20 East Main
1912 Dillon, John Henry, 325 East Main
1951 DiLorenzo, Albert T., 278 East Main
1948 DiLorenzo, Salvatore F., 195 Grove
1941 Dionne, Ulric Albany, 64 Holmes Ave.
1927 Dreher, Alfred Charles, 171 North Main
1941 DuBois, Robert Lionel, 29 Central Ave.
1947 Dwyer, Christopher Edward, 18 Pine
1902 Dwyer, Patrick James, 95 North Main
1927 Edlin, Charles, 24 Central Ave.
1922 Fabricant, Samuel Elmer, 9 Cooke
1937 Finkelstein, William, 103 North Main
1926 Finn, Alfred Joseph, 164 West Main
1926 Fitzpatrick, Edward Earl, 111 West Main
1927 Foster, John Hess, 77 North Main
1928 Freiheit, John Martin, 85 Grove
1909 Gancher, Jacob, 275 North Main
1951 Good, Philip Snowden, 98 Coniston Ave.
1949 Good, Robert Childers, 63 Center
1914 Good, William Murray, 63 Center
1915 Green, Jacques Henry, 171 North Main
1947 Grillo, William, 56 Franklin
1947 Gualtieri, Michael Vincent, 27 Cooke
1942 Harty, John E., 101 North Main
1949 Hawley, Katharine Jaqueth, 35 Field
1930 Herrmann, Albert Edward, 87 North Main
1931 Hetzel, Joseph Linn, 51 Central Ave.
1939 Hinchey, Richard James, 43 Central Ave.
1919 Jackson, Andrew Joseph, 111 West Main
1942 Jennes, Milton Leo, 14 Central Ave.
1939 Jennes, Sidney Weinberg, 135 West Main
1922 Johnson, Arthur August, 59 Central Ave.
1915 Johnston, Ernest Hillock, 51 West Main
1944 Karlin, Frank Lewis, 95 North Main
1946 Kelly, LeMoyne Copeland, 95 North Main and 55 Trumbull, New Haven
1914 Kirschbaum, Edward Harry, 20 Grove
1944 Koleshko, Lawrence Jacob, 24 Central Ave.
1940 LaBrecque, Frederick Charles, 175 Grove
1922 Larkin, Charles Lewis, 101 North Main
1945 Lenkowski, William John, 207 South Elm
1941 Lewicki, Edward Stanley, 36 North Main
1924 Lombardi, Pasquale Frederick, 46 Prospect
1948 Lovelace, Theodore Ronceverte, 227 North Elm
1939 Margolius, Norman Calvin, 50 Holmes Ave.
1941 Mayo, Elliott Russell, 129 Prospect
1916 McGrath, John Henry, 309 East Main
1943 Meo, Richard Carl, 195 Grove
1941 Merriman, Henry, 115 Prospect
1925 Merriman, Merritt Heminway, 115 Prospect
1947 Monagan, Thomas M., 195 Grove
1928 Morrill, Harold Frost, 300 West Main
1932 Mullen, John Joseph, 135 West Main
1947 Mulligan, Thomas Michael, 19 Holmes Ave.
1929 Neuswanger, Chris Harold, 89 North Main
1948 Olore, Louis, 195 Grove
1942 Pasetto, Edo, 63 Central Ave.
1923 Platt, Irving Smith, 30 Prospect
1943 Pollard, Robert Lonsdale, 24 Central Ave.
1901 Pomeroy, Nelson Asa, 96 Hillside Ave.
1931 Pyle, Edwin, 95 North Main
1916 Quinn, Raymond James, 730 Baldwin
1941 Reichenbach, Alfred Edelbert, 64 Cooke
1939 Reynolds, Joseph Alban, 185 Pine
1941 Riccio, Joseph Salvatore, R. F. D. No. 3
1920 Root, J. Harold, 103 North Main
1947 Root, James Harold, Jr., 103 North Main
1946 Rosenberg, Harold Arthur, 29 Central Ave.
1925 Ruby, Max Harold, 47 Prospect
1939 Ruby, Robert James, 47 Prospect
1914 Ryder, Raymond Harrison, 52 Central Ave.
1941 Saltzman, Jacob A., 135 West Main
1931 Sandulli, Gaetano Renato, 64 Cooke
1928 Santoro, Grace Marie, 95 North Main
1939 Sayers, Daniel O'Connell, 132 Eastfield Rd.
1933 Shea, Vincent Timothy, 20 East Main
1948 Shearer, John Kennedy, 89 North Main
1941 Sklaver, Joseph, 95 North Main
1935 Slavin, Joseph E., 79 North Main
1946 Smith, Jasper Archer, 77 Central Ave.
1931 Staneslow, John Stanislovaitis, 21 Holmes Ave.
1924 Stettbacher, Henry John, 28 Prospect
1946 Sullivan, Arthur Francis, 111 West Main
1906 Swenson, Andrew Clay, 43 Central Ave.
1947 Teiger, Paul, 58 Holmes Ave.
1947 Tynan, James G., 64 Holmes Ave.
1916 Vastola, Anthony Patrick, 103 North Main

1920 Webber, Edwin Russell, 95 North Main
1946 Whalley, Evan Joseph, 720 Baldwin
1949 Yavetz, Louis Milton, 95 North Main
1943 Zerkowitz, Frederick, 79 North Main and 1 Divinity, Bristol
1942 Zonn, Seymour Israel, 34 Holmes Ave.
1951 Zucker, Reuben, 159 Grove

WEST HAVEN

1938 Chasnoff, John Arthur, 328 Main
1943 Cozzolino, Eugene Norris, 640 Savin Ave.
1951 Dzubaty, Michael, 457 Ocean Ave.
1923 Giannotti, Carl Charles, 399 Savin Ave.
1943 Kessler, Frederick, 233 Elm
1940 Koster, Leo William, 381 Main
1930 Milano, Nicolas Antonio, 271 Elm
1947 Milici, John Joseph, 354 Campbell Ave.
1923 O'Connell, William Michael, 295 Main
1915 Rogers, Platt Harrison, 228 Elm
1945 Saposnik, Jacob Jay, 610 Campbell Ave.
1933 Snavely, Marion Elizabeh, 546 Washington Ave.
1950 Vinograd, Abraham, 1225 Campbell Ave.

OUT OF COUNTY

1941 Aiello, Louis James, 394 West Ave., Norwalk
1909 Beck, Frederick George, Ray Brook Hospital, Ray Brook, N. Y.
1949 Berman, Sidney, Veterans Hospital, Newington
1948 Biehusen, Frederick Charles, Madigan General Hospital, Tacoma, Wash.
1907 Blumer, George, 573 Los Arboles Lane, San Marino 10, California
1951 Brinkley, Sterling Brownlee, 235 Franklin, Johnstown, Penn.
1951 Brook, David Leonard, Deer Park, Greenwich
1924 Carroll, William Edward, 470 Park Ave., East Orange, N. J.
1949 Chiffele, Thomas Laughlin, Lovelace Clinic, Albuquerque, New Mexico
1921 Creadick, A. Nowell, State Veterans Hospital, Rocky Hill
1946 Curnen, Edward Charles, Jr., Univ. of North Carolina, Chapel Hill, North Carolina
1946 Day, Harry Luther, U. S. Naval Hospital, St. Albans, N. Y.
1941 Dayton, Theodore Read, V. A. Hospital, Rutland Hgts., Mass.
1950 Doe, Thomas Aiquier, 6 Temple, Springfield, Mass.
1922 Duffy, Vincent P., R. F. D. 5, Box 63A, Brounlow Park, Grafton, West Virginia
1937 Eliot, Martha May, 4802 Jamestown Rd., Washington 16, D. C.
1935 Fenney, Philip William, V. A. Hospital, Ft. Howard, Maryland
1946 Foord, Alan, Johns Hopkins Univ. School of Medicine, Baltimore, Maryland
1950 Friou, George J., Veterans Hospital, Newington
1951 Fuhrmann, Josephine Marie, Pratt & Whitney Aircraft, East Hartford
1946 Gardner, Horace Tillman, Brookhaven National Laboratory, Upton, Long Island, N. Y.
1950 Goade, William J., Jr., N. E. Center Hospital, Harrison, Boston, Mass.
1943 Harvey, Thomas Stoltz, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Penn.
1946 Howard, Weaver Oscar, Veterans Hospital, Tuskegee, Alabama
1927 Johnson, Harold Albert, R. F. D. No. 2, Watertown
1948 Kennedy, John Joseph, Jr., 5 North Main, Windsor Locks
1936 Klumpp, Theodore George, 1450 Broadway, New York, N. Y.
1951 Kroeger, Hilda Hertha, Elizabeth Steele Magee Hospital, Pittsburgh, Pa.
1950 Lawrason, F. Douglas, 2101 Constitution Ave., Washington, D. C.
1935 Leddy, Percy Allen, University of Maine, Orono, Maine
1907 Leonard, George Arthur, V. A. Hospital, Big Spring, Texas
1906 McLarney, Thomas Joseph, 67 Catherine, Hartford
1949 McLean, Charles Ellsworth, 946 Highland Ave., West Apt. Kenmore 23, N. Y.
1952 Nelson, William Pierpont, III, Albany V. A. Hospital, 113 Holland Ave., Albany, N. Y.
1948 Pappenheim, Else, 225 West 86th, New York City
1894 Peck, Robert Ellsworth, R. F. D. No. 2, Concord, New Hampshire
1940 Post, Edward Andrew, 135 Powell Lane, Upper Darby, Pa.
1950 Ravitz, Leonard Jolian, 13800 Fairhill, South Parkmanor, Shaker Heights, Ohio
1945 Sachs, Kurt, V. A. Hospital, New Orleans 12, La.
1949 Skorneck, Alan Bernard, V. A. Hospital, Newington
1936 Stevens, Marvin Allen, 71 Park Ave., New York, N. Y.
1942 Tarbell, Luther Allen, Peddie School, Heightstown, N. J.
1936 Van Antwerp, Lee Douglas, Box 5110, Chicago, Ill.
1945 Wagner, Herbert Theodore, Jr., National Foundation for Infantile Paralysis, 120 Broadway, New York, N. Y.
1907 Wheatley, Louis Frederick, Randolph Center, R. F. D., Brookfield, Vermont
1921 Winternitz, Milton Charles, The Nat'l Research Council, 2101 Constitution Ave., Washington, D. C.
1933 Zimmerman, Harry Martin, Montefiore Hospital, New York City

New London County Association

President: William Wener, 241 Main St., Norwich
Vice-President: Isidore Hendel, 50 State St., New London
Secretary-Treasurer: David G. Rousseau, Ponemah House, Taftville
Councilor: Alfred Labensky, 85 Federal St., New London
Alternate Councilor: Henry A. Archambault, 2 North Second Ave., Taftville

Annual Meeting, First Thursday in April
Semi-Annual Meeting: First Thursday in October

COLCHESTER

1935 Friedman, Irving, 16 Norwich Ave.

EAST LYME

Niantic

1949 Dey, Frederick Lemuel, 61 Main
1948 Duennebier, Harold W., Lincoln
1934 MacLeod, Edith Alice, State Farm for Women

GALES FERRY

1935 Hale, Virginia Anne, P. O. Box 92

GRISWOLD

Jewett City

1950 Barrett, Frederick Charles, 110 Main
1934 O'Neil, Martin Leo, 8 Park Sq.

GROTON

1918 Douglass, Edmund Latham, 188 Thames
1934 Hewes, Carlisle Tyson, 242 Thames
1946 MacDougall, A. Duncan, 242 Thames
1944 Sutton, Paul, 280 Mitchell
1942 Szlemko, Emil Alex, 27 Poquonnock Rd.

LYME

1927 Ely, Julian Griffin, R. F. D. No. 2

MONTVILLE

Uncasville

1944 Donohue, John Daniel
1949 Miselis, Frank Joseph, Main Rd.
1929 Rasmussen, Hans Norman

NEW LONDON

1947 'Agrin, Alfred, 961 Ocean Ave.
1948 'Ansprenger, Aloys George, 35 Huntington
1933 Becker, Joseph, 302 State
1928 Blank, Eric Henry, 326 State
1933 Brosnan, John Francis, 302 State
1916 Cheney, George Philip, 179 Montauk Ave.
1936 Comstock, Edward Richard, 108 State
1951 Davis, Kelley King, 154 Williams
1938 DeAngelis, Louis, 260 Broad
1931 Dyer, Charles Edward, 102 Montauk Ave.
1948 Ellison, Malcolm Mitchell, 334 Montauk Ave.
1948 Fabricant, Milton W., 275 Montauk Ave.
1947 Fagan, Frederick J., Lawrence Memorial Hospital
1936 Ferguson, Helen Knox, 508 Montauk Ave.
1948 Gager, John Jay, 302 State
1906 Ganey, Joseph Matthew, 205 Williams
1948 Ganey, Joseph Matthew, Jr., 205 Williams
1934 Gipstein, Edward, 181 Broad
1949 'Goodrich, Frederick Warren, Jr., 326 State
1947 Grayson, Merrill, 183 Williams
1952 Griffith, Bezaleel Herold, U. S. Submarine Base (Box 11)
1947 Haines, Henry Lippincott, 309 State
1939 Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidore, 50 State
1934 Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 Irwin, Harold Hyman, 158 Williams
1947 Karpel, Saul, 116 Federal
1921 Kaufman, Charles, 308 State
1940 Krinsky, Charles Morris, 302 State
1924 Labensky, Alfred, 85 Federal
1931 Loiacono, Anthony Joseph, 262 Broad
1947 Loiacono, Richard A., 260 Broad
1936 Lubchansky, Jacob Harris, 302 State
1949 McFarland, Ward John, 833 Ocean Ave.
1934 Morse, Willard Jackson, 32 Channing
1952 Murray, Joseph Thomas, U. S. Submarine Base
1946 Nielsen, Tage M., 240 Williams
1951 Olsen, Robert Clarence, 496 Montauk Ave.
1950 'Owre, E. Stewart, Lawrence Memorial Hospital
1951 Pils, Arnulf Remigius, 50 Granite
1929 Satti, C. John, 131 Montauk Ave.
1938 Smilgin, Victor Edward, 265 Williams
1921 Soltz, Thomas, 52 Huntington
1949 Spitz, Hilliard, 183 Williams
1929 Starr, Richard Mallory, 45 Huntington
1951 Steinecke, Olga, 69 Fair Harbour Pl.
1951 Stone, Eugene Carroll, U. S. Submarine Base
1942 Sturtevant, James Melvin, 58 Huntington
1940 Sulman, Morris, 203 Montauk Ave.
1933 Taylor, Robert Nelson, 159 State
1951 Traggis, Demetrius George, 325 State
1947 Verie, Kathryn E., 159 Ocean Ave.
1950 Warnshuis, Lilian Cook, Connecticut College
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 'Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1938 Woodward, Joseph Cutler, 116 Federal
1947 Wool, Joseph M., 183 Williams

NORWICH

1950 'Aey, Arthur Edward, 10 Shetucket
1910 Agnew, Robert Robertson, 257 Main
1946 Albamonti, Mario John, 257 Main
1950 Allen, Joseph Eugene, Norwich State Hospital
1950 'Anderson, Fred Andrew, 257 Main
1950 Anderson, Ruth Messer, 257 Main
1935 Bergendahl, Harold Andrew, 63 Broadway
1942 Bielecki, Casimer Eugene, 35 Main
1951 Birchall, Ellen Frances, Box 508
1916 'Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, 111 Broad
1950 Carbone, Hubert Alfred, Norwich State Hospital
1947 Carey, Thomas B., Uncas-on-Thames
1950 Carroll, Gerald Joseph, William Backus Hospital
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1942 Drobnes, Sidney, 71 Main
1942 Ferrara, Michael, Uncas-on-Thames
1927 Gildersleeve, George Harold, 310 Main
1948 Guss, Louis, 71 Main
1935 'Higgins, Harold William, 40 Shetucket
1947 Katz, Morris E., 16 Franklin
1946 Kelley, Winfield Orthello, Uncas-on-Thames
1938 Kettle, Ronald Harry, Norwich State Hospital
1947 LaPierre, Arnaud R., 187 Main
1949 LaPierre, Warren Winthrop, 10 Shetucket
1950 'Lord, Benjamin John, Jr., 16 Franklin
1936 'Mahoney, Joseph John, 99 Main
1922 'Manwaring, Ier Jay, East Great Plains
1947 Martin, John Edward, 45 Main
1937 'Moore, Maurice R., 88 Central Ave.
1951 Morrison, John Edward, Norwich State Hospital
1935 O'Connell, Patrick Henry, 10 Shetucket
1942 'Oppenheimer, Kurt, 257 Main
1936 Osgood, Charles, 26 Canterbury Tpke.
1942 Pepe, Anthony James, Norwich State Hospital
1947 Peterson, Eloise B., Drawer 508, Norwich
1934 Quintiliani, Albert, 58 Broadway
1952 Rabinovitch, Alec, 16 Franklin
1950 Ranger, Conrad Orphila, Norwich State Hospital
1930 Raymer, John George, 59 McKinley Ave.
1942 Schwarz, H. Peter, 25 Main
1935 Sears, Lewis, 257 Main
1938 'Segel, Solam, 257 Main
1950 Simmel, Else Rose, Uncas-on-Thames
1944 Smith, Bryce A., Uncas-on-Thames
1929 Suplicki, John William, 257 Main
1921 'Sussler, David, 65 Main
1952 Suttles, Charles McClellan, 16 Franklin
1950 Taylor, Malcolm Cushing, Norwich State Hospital
1925 Thompson, Clarence George, 257 Main
1951 Tillinghast, Jane Wasson, Box 508
1951 Turner, Howard Griffin, Jr., Uncas-on-Thames
1935 'Weidman, William Harold, R. F. D. No. 8, Scotland Rd.
1932 Wener, William Victor, 241 Main
1933 Wilson, George Campbell, Uncas-on-Thames
1952 Wood, George W., III, Uncas-on-Thames

TAFTVILLE

1933 Archambault, Henry Allard, 2 North Second Ave.
1949 Rousseau, David George, Ponemah House

OLD LYME

1909 Devitt, Ellis King
1947 Von Glahn, Harold Diedrich, Ferry Rd.

STONINGTON

1934 Haliday Earle George, 168 Water
1934 Veal, William Thomas, 99 Water

MYSTIC

1947 Crandall, Bradford Blanchard, 31 Gravel
1950 Edmonstone, William Mason, 22 Library
1941 Fowler, Roger Nathaniel, 21 East Main
1928 Hill, Edward Roland, 43 East Main
1941 Ryley, Roger Noyes, 19 Gravel

WATERFORD

1946 Coppola, Edward Attilio, 2 Highland Dr.
1935 Lukoski, Walter Anthony Francis, The Seaside
1913 O'Brien, John Francis, Park Dr., Oswegatchie
1901 Sullivan, Daniel, Best View Rd.
1942 'Tombari, S. Paul, The Seaside

OUT OF COUNTY

1943 Goldmeier, Erich, 330 Brookline Ave., Boston, Mass.
1952 Griffith, Bezaleel Herold, 319 Avenue C, Apt. 10G, New York City
1946 Mezey, Cornelius M., Station B, Gulfport, Mississippi
1947 'Phillips, Nicholas T., Waterbury Hospital, Waterbury
1951 Schloss, Gerd Tobias, 516 Alger, S.E., Grand Rapids, Michigan
1935 Vernon, Sidney, 55 High, Willimantic

Tolland County Association

President: ELLIOTT H. METCALF, 50 Elm St., Rockville
Vice-President: SEYMOUR I. KUMMER, 62 Park St., Rockville
Secretary: R. BRUCE THAYER, JR., Main, Hazardville
Councilor: JOHN E. FLAHERTY, 42 Elm St., Rockville

Annual Meeting, Third Tuesday in April
Semi-Annual Meeting, Third Tuesday in October

SOMERS

1921 'Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1946 Detora, Albert M., 53 East Main
1908 Hanley, John Patrick, 15 Church
1941 Luckner, Wendelin George
1935 'Schiavetti, Alfred, 11 Church

VERNON

ROCKVILLE

1933 Burke, Francis Henry, 45 Park
1908 Dickinson, Francis McLean, 38 Elm
1923 Ferguson, Roy Cameron, 57 Union
1918 Flaherty, John Edward, 42 Elm
1950 Kummer, Seymour Isaac, 62 Park
1921 Metcalf, Elliott Harrison, 50 Elm
1952 Purnell, Marjorie Axford, 23 Davis Ave.
1931 Schneider, William, 72 Orchard

OUT OF COUNTY

1950 Glaubman, William, Main, Warehouse Point
1946 Squillante, Orlando John, 247 County Rd., Barrington, R. I.
1949 Thayer, R. Bruce, Jr., Main, Hazardville

Windham County Association

President: CECIL R. GARCIN, 7 Broad St., Danielson
Vice-President: NEIL A. DAYTON, Mansfield Training School, Mansfield Depot
Secretary: WALTER ROWSON, JR., North Grosvenordale
Councilor: KARL T. PHILLIPS, 66 Main St., Putnam
Alternate Councilor: WILLIAM M. SHEPARD, 66 Main St., Putnam

Annual Meeting, Third Thursday in April
Semi-Annual Meeting, Third Thursday in October

ABINGTON

1948 'Valentine, Bruce, Eliza F. Clark Memorial Center

HAMPTON

1949 Hetrick, Llewellyn Evans, R. F. D. No. 2
1914 'Marsh, Arthur Drought

KILLINGLY

DANIELSON

1935 'Chartier, Gerard Marcel, 39 Broad
1928 'Garcin, Cecil Redvers, 7 Broad
1949 'Jones, James Franklyn, 39 Broad
1940 Laakso, Andrew Olavi, 39 Broad
1909 Perreault, Joseph Napoleon, 43 Main
1919 'Tanner, Warren Avery, 36 Academy
1949 'Weigel, Stanley Joseph, 53½ Broad

MOOSUP

1948 Barry, E. Arthur, Jr., Main
1940 'Couture, Arthur Joseph, 19 South Main
1946 'Woodworth, John Albert, 1 Main

NORTH GROSVERNORDALE

1948 Rowson, Walter, Jr.

PLAINFIELD

1903 Chase, Arthur Alverdo, Railroad Ave.
1933 'Gulino, Angelo James

PUTNAM

1942 Bates, David Hinrichs, 28 Front
1934 Chapnick, Morton Herman, 168 Main
1947 'Dinolt, Robert, Bradley Theater Building
1948 LaPalme, Leo, 158 Main
1941 Margolick, Moses, 212 Main
1921 Phillips, Karl Tristram, 66 Main
1930 Prosser, Florence Dean, 158 Main
1934 Shepard, William Mac, 66 Main

THOMPSON

1948 'Stevenson, Edward Vicars, Jr.
1950 'Stevenson, Jean Keiser

WINDHAM

WILLIMANTIC

1949 Anderson, James Thomas, 902 Main
1935 'Arnold, Morton, 29 North

1939 Basden, Edward Herbert, 820 Main
1950 Beardsley, Frederick Armour, 781 Main
1939 Carter, George Howard, 29 North
1901 Girouard, Joseph Arthur, 19 Union
1949 Hainsworth, Winston Clarkson, 670 Main
1928 Kinney, Kenneth Kyle, Windham Community Hospital
1942 Leary, Deborah Cushing, 59 Church
1940 Little, Mervyn Henry, 715 Main
1940 Little, Olga A. G., 715 Main
1948 Major, James W., Windham Community Hospital
1947 Maurer, William Spooner, 670 Main
1949 Medbury, Sawyer Eldredge, Mansfield Ave.
1948 Newcombe, Richard Vaughan, Windham Community Hospital
1925 Ottenheimer, Edward Joseph, Windham Community Hospital
1932 Rafferty, Brae, 807 Main
1936 Roch, George E. 20 North
1937 Rothblatt, Reuben, 886 Main
1914 Smith, Fred Morse, 736 Main
1929 Spector, Nathan, 59 Church

WOODSTOCK

EAST WOODSTOCK

1913 Pike, Ernest Reginald

OUT OF COUNTY

1948 Collier, Fred Clark, Cleveland Clinic, Cleveland, Ohio
1946 Dayton, Neil Avon, State Training School, Mansfield Depot
1946 Flynn, Herbert Lawrence, Mansfield State Training School, Mansfield Depot
1932 Gilman, Ralph Lawrence, Storrs
1950 Goodchild, Franklyn Myers, University of Connecticut, Storrs
1896 Hills, Laura Heath, Winter Haven, Florida
1946 Moxon, Gail Fitch, State Training School, Mansfield Depot
1948 Nowrey, Joseph Edward, Mansfield State Training School
1950 Orr, Harry Dawson, Jr., Main, South Coventry
1951 Schenck, Kenneth, University of Connecticut, Storrs

Associate Members

1941 Burr, Harold Saxton, 333 Cedar, New Haven
1948 Crankshaw, Charles William, Pleasant Valley Rd., South Windsor
1947 Darling, George Bapst, Woodbridge Hall, Yale University, New Haven
1941 Fulton, John Farquhar, 333 Cedar, New Haven
1941 Haggard, Howard W., 4 Hillhouse Ave., New Haven
1942 Hamilton, James A., University of Minnesota, Minneapolis, Minn.
1941 Hiscock, Ira Vaughn, 215 Highland, New Haven
1941 Long, Cyril Norman Hugh, 333 Cedar, New Haven
1941 Mickle, Friend Lee, P. O. Box 2340, Hartford
1949 Mooney, Grace, 388 Whalley Ave., New Haven
1943 Schneider, Edward Christian, Wesleyan University, Middletown

ALPHABETICAL ROLL OF MEMBERS

With date and school of graduation

Aaronson, M. S., Univ. & Bellevue '13, Ansonia
Abrahams, M., Tufts '31, New Canaan
Abrahamson, R. H. McGill '30, Stamford
Acqua, L. C., Yale '41, East Hartford
Adam, A. B., Colorado '38, Stamford
Adam, F. S., Yale '25, Canaan
Adams, A. J., Indiana '38, Torrington
Adams, E. C., Cornell '34, Guilford
Adams, M., Johns Hopkins '29, Greenwich
Adzima, J. M., Maryland '27, Bridgeport
Aey, A. E., Pennsylvania '43, Norwich
Affinito, T., McGill '31, Meriden
Agnew, R. R., Yale '08, Norwich
Agrin, A., Tufts '44, New London
Aiello, L. J., Boston '35, Norwalk (New Haven County)
Akerson, I. B., Iowa '25, Bridgeport
Albamonti, M. J., Tufts '38, Norwich
Albis, F. J., Marquette '46, New Haven
Albis, M. D., Marquette '48, Hamden
Albom, J. J., Columbia '39, New Haven
Alderman, I. S., Columbia '19, New Haven
Aldwin, F. J., Yale '32, Meriden (Fairfield County)
Alexander, S. J., Univ. & Bellevue '32, Middletown
Allen, B. I., Washington '32, Meriden
Allen, E. P., Yale '24, New Haven
Allen, G. F., McGill '37, Hartford
Allen H. E., Bowdoin '19, Waterbury
Allen, J. C., Hahnemann '39, Hartford
Allen, J. E., Syracuse '30, Norwich
Allen, M. F., Med. Chi., Phila. '95, New Haven
Allen, M. M., Woman's Medical '35, Hartford
Allen, R., Temple '43, West Hartford
Allen, W. M., Johns Hopkins '20, Hartford
Allinson, M. J. C., Arkansas '45, New Haven
Alpert, M., Yale '28, Bridgeport
Alu, A. F., Yale '20, Ansonia
Amarant, L., Vienna '32, Bridgeport
Amatruda, F. G., Yale '23, New Haven
Ames, W. G., Columbia '38, Essex
Amico, P. J., N. Y. Med. Coll. '47, Cos Cob
Amos, I. L., McGill '26, Danbury
Amoss, H. L., Harvard '11, Greenwich
Anderson, C. W., Harvard '34, Greenwich
Anderson, F. A., Boston '40, Norwich
Anderson, J. O., Georgetown '38, West Hartford
Anderson, J. T., Pennsylvania '43, Willimantic
Anderson, R. M., Boston '40, Norwich
Andrews, E. M., Harvard '30, Hartford
Andrus, D. S., Pennsylvania '37, Meriden
Andrus, O. B., Univ. & Bellevue '32, Devon
Angelini, H. D., Tufts '45, Hartford
Ansprenger, A. G., Munich '32, New London
Antell, M. J., Vermont '29, Bridgeport
Anton, M. C., Marquette '39, Stratford

Antupit, L., Jefferson '23, Hartford
Appell, H. S. Tufts '27, New Haven
Appell, P. H., Univ. & Bellevue '23, Bristol
Apsel, A., Long Island '18, Bridgeport
Apter, H., George Washington '34, Hartford
Apuzzo, A. A., Tufts '36, Bridgeport
Archambault, H. A., Tufts '27, Taftville
Arnold, H. B., Yale '26, New Haven
Arnold, M., Harvard '29, Willimantic
Arons, M. R., Maryland '30, Hartford
Arst, D. B., Kansas '44, Newington
Ashcroft, A. D., Columbia '35, Stratford
Atchley, J. A., Columbia '44, New Canaan
Atkins, R. T., N. Y. U. '43, Old Greenwich
Atkins, S. M., Tufts '22, Waterbury
Atwood, A. S., Yale '45, Torrington (Hartford County)
Aube, L. A., McGill '43, Bridgeport
Audet, C. H., Maryland '17, Waterbury
Aune, E. F., Long Island '44, East Hartford
Ayers, C. M., Rome '34, Middletown
Ayres, P. B., Toronto '32, Cos Cob

Backer, M., Yale '24, Bridgeport
Backhus, L. C., Syracuse '33, Waterbury
Backus, H. S., Long Island '03, Hartford
Badner, D. H., N. Y. U. '41, Meriden
Baer, I. N., Southern California '35, New Haven
Bagnall, R. S., Harvard '43, Bloomfield
Bailey, N. H., P. & S., Balt. '11, Hartford
Baird, R. D., Washington '33, New Milford
Baker, A. L., Virginia '28, Portland
Baker, P. G., Vermont '33, Winsted
Bakunin, M. I., Jefferson '32, Bridgeport
Balletto, V., Tufts '33, East Haven
Bancroft, H. A., Albany '16, Hartford
Banfield, W. G., Yale '46, New Haven
Banks, D. T., Fordham '12, Bridgeport
Bannister, W. K., Ohio '40, Hartford
Bannon, F. M., Vermont '28, Stamford
Baptist, V., Boston '42, Bristol
Barber, W. L., Jr., Univ. & Bellevue '07, Waterbury
Barber, R. R., Vermont '30, Stamford
Barbour, C. M., Jr., McGill '38, Hartford
Barbour, P. H., Jr., Yale '41, Farmington
Bard, D. G., Jr., Duke '43, Suffield
Barker, C., Dartmouth '13, New Haven
Barker, D. C., Maryland '40, Fairfield
Barker, N. J., Toronto '26, Hartford
Barnes, F. H., N. Y. Homeo. '96, Stamford
Barnett, R. N., Yale '38, Norwalk
Barney, W. E., Yale '35, Milford
Barrett, F. C., Vermont '46, Jewett City
Barrett, H. S., Harvard '41, Hartford
Barringer, P. L., Jefferson '42, Windsor, North Carolina (Fairfield County)
Barry, E. A., Jr., Laval '46, Moosup
Barry, J. C., Boston '33, Manchester
Barstow, R. I., Jefferson '33, Norfolk
Bartlett, C. J., Yale '95, New Haven
Barton, P. N., Harvard '39, Terryville (Hartford County)
Basden, E. H., Tufts '33, Willimantic
Baskin, A. H., Minnesota '32, Elmwood
Bassin, A. L., Rochester '30, New Haven
Batelli, C. F., Yale '28, New Haven
Bates, D. H., Long Island '39, Putnam
Battista, A. W., Tufts '24, New Haven
Bauer, W. F., Jr., N. Y. Med. Coll. '50, Middletown
Baum, S. J., Vermont '48, Bridgeport
Bausch, C. P., Tufts '29, Hartford
Beach, C. T., Yale '05, Hartford
Beaky, J. F., Tufts '43, Hartford
Beaman, G. B., Harvard '34, Noroton
Beardsley, F. A., Cornell '43, Willimantic
Beardsley, L. G., Yale '17, Newington
Beatman, I., Tufts '27, Hartford
Beatrice, A. A., Tufts '29, Bristol
Beattie, G. F., Michigan '40, Sharon
Beaty, H. W., Cornell '31, Meriden
Beaty, J. T., Columbia '43, Greenwich
Beauchamp, L. A., Vermont '44, Waterbury
Beauchamp, M. F., Vermont '43, New Haven
Beauchemin, J. A., Montreal '25, Middletown
Beaudry, J. H., McGill '13, Bridgeport
Beck, E. C., Yale '26, South Norwalk
Beck, F. G., Yale '03, Ray Brook, New York (New Haven County)
Beck, S. H., Rochester '34, Bridgeport
Becker, A. H., Vermont '43, Bristol
Becker, J., Univ. & Bellevue '29, New London
Beckett, R. S., Yale '40, Hartford
Beckwith, D. M., Harvard '34, East Haven
Beebe, J. T., Columbia '38, Hartford
Behan, E. J., McGill '22, New Haven
Beizer, E., Long Island '30, Hartford
Bell, J. S., Illinois '28, Ridgefield
Bellach, H., Long Island '33, New Britain
Bellew, R. F., Tufts '37, Bridgeport
Bellizzi, J. J., Tufts '47, Hartford
Beloff, J. S., Columbia '43, Meriden
Benedict, M. K., Johns Hopkins '19, New Haven
Benoit, R. J., Georgetown '26, New Britain
Bergendahl, H. A., Tufts '33, Norwich
Berger, A. J. Harvard '40, New Britain
Bergeron, L. N., McGill '42, Rochester, New Hampshire (Fairfield County)
Bergin, T. J., Yale '99, Cos Cob
Berlowe, M. L., Long Island '34, New Haven
Berman, H. L., Yale '15, New Haven
Berman, S., Long Island '43, Newington (New Haven County)
Berneike, R. R., Western Reserve '41, New Haven
Bernstein, A., Yale '08, Bridgeport
Bernstein, D. J., Vermont '33, New Britain
Bernstein, L., Berne '36, Hartford
Berwick, P., N. Y. Med. Coll. '38, Moodus
Besser, E. L., Johns Hopkins '37, Manchester
Bestor, E. L., N. Y. Homeo. '07, Hartford
Bevans, T. F., Minnesota '03, Waterbury
Biehn, D. M. F., Queen's '37, Fairfield
Biehn, S. L., Toronto '26, Fairfield
Biehusen, F. C., Yale '46, Tacoma, Washington (New Haven County)
Bielecki, C. E., Tufts '39, Norwich
Bineau, A. G., Syracuse '48, Greenwich
Bingham, C. T., Columbia '32, Rocky Hill
Biondi, B., Tufts '38, New Haven
Birchall, E. F., Vermont '47, Norwich
Bird, F. S., Vermont '33, Bristol
Birge, H. L., Pennsylvania '33, Hartford
Birnbaum, H. B., Royal Coll. England '35, Madison
Birney, T. P., Northwestern '39, Bridgeport
Bisharat, M. H., Amer. Univ. of Beirut '43, Torrington
Bishop, C. C., Yale '30, New Haven
Biskind, M. S., Western Reserve '30, Westport
Bissell, A. H., Cornell '16, Stamford
Bixby, H., Tufts '35, Mansfield Depot (Middlesex County)
Bizzozero, O. J., Vermont '27, Waterbury
Black, S. P. W., Johns Hopkins '43, New Haven

Blaine, G. B., Jr., Columbia '43, Stockbridge, Mass. (Litchfield County)
Blake, E. M., Yale '06, New Haven
Blakeslee, M. R., Syracuse '25, Portland
Blanchard, D. L., Yale '31, Branford
Blaney, C. C., Boston '40, Bridgeport
Blank, E. H., Vermont '25, New London
Blank, S., Virginia '41, Waterbury
Blansfield, H. N., Yale '47, Waterbury
Blass, G., Vienna '24, Stamford
Blau, R., Friedrich Wilhelms '20, Waterbury
Blinkoff, J. J., Berne '37, Torrington
Blodinger, I. E., Yale '25, New Haven
Blogoslawski, W. J., Georgetown '27, New Britain
Bloom, D. I., Tufts '35, Thompsonville
Bloomberg, M., Tufts '24, Waterbury
Bloomer, W. E., Yale '42, New Haven
Blossom, D. B., Columbia '38, Greenwich
Bluestone, D. H., Syracuse '12, Naugatuck
Blumenthal, E. J., Long Island '32, Ansonia
Blumer, G., Cooper '91, San Marino, California (New Haven County)
Boardman, A. K., Pennsylvania '99, New Haven
Bobrow, A., Berne '36, Hartford
Bodie, J. A., Tufts '24, New Haven
Bodie, W. J., Georgetown '29, Branford
Bogin, M., Yale '26, Bridgeport
Boguniecki, S. J., Harvard '40, Meriden
Bohan, G. N., Beirut '44, North Haven
Boisvert, P. L., Rochester '34, Orange
Bolton, J. D., Hahnemann '43, Greenwich
Bonner, R. A., Maryland '12, Waterbury
Bonner, R. A., Jr., Maryland '38, Waterbury
Bonnett, D. N., Illinois '43, Greenwich
Booe, J. G., Med. Coll. Va. '19, Bridgeport
Booth, J. D., Columbia '26, Danbury
Borkowski, B. J., Georgetown '28, Bristol
Bornemann, C., N. Y. Med. Coll. '40, Canaan
Boshnack, M., N. Y. Medical Coll. '43, Stamford
Botsford, C. P., Yale '94, Hartford
Bowen, F. D. T., Maryland '42, Hartford
Bowen, J. J., Jr., Maryland '41, Waterbury
Bowman, S. H., Hahnemann, Chicago '13, Stamford
Boyarsky, H. M., Tufts '31, Wallingford
Boyd, H., Harvard '21, South Manchester
Boyd, R. B., Tufts '41, Wallingford
Braceland, F. J., Jefferson '30, Hartford
Brackett, A. S., Jefferson '95, Bristol
Bradeen, F. B., Pennsylvania '99, Essex
Bradley, E. T., Cornell '36, Norwalk
Brainard, C. B., Yale '98, West Hartford
Brand, E. S., N. Y. U. '43, New Haven
Brandon, K. F., Toronto '32, Hartford
Brandriss, J., Columbia '26, Hartford
Branon, A. W., Jefferson '13, Hartford
Braun, R., Vienna '29, Bridgeport
Brayton, H. W., Harvard '11, Hartford
Breck, C. A., Yale '30, Wallingford
Breck, R. W., Yale '45, Wallingford
Brecker, F. W., Tufts '28, Hartford
Brennan, E. L., Natl. Univ., Ireland '23, Hartford
Brennan, P. J., Yale '07, Waterbury
Bretzfelder, K. B., Jefferson '16, New Haven
Brewer, A. E., N. Y. U. '41, Salisbury
Brewer, F., Columbia '20, Bloomfield (Fairfield County)
Brewer, T. F., Yale '26, Hartford
Brewster, W. B., Jr., Harvard '42, Hartford
Brezina, P. S., Yale '40, Bristol
Bria, W. F., Rome '34, Cos Cob
Bridge, J. L., Harvard '03, Hazardville
Brier, H. D., N. Y. U. '34, Bridgeport
Brinkley, S. B., Yale '43, Johnstown, Pa. (New Haven County)
Bristoll, D. A., Pennsylvania '27, New Britain
Broady, H., St. Louis '41, Meriden
Brochu, E. D., Boston '33, Danbury
Brock, W. H., McGill '45, Old Greenwich
Brockway, D. W., Long Island '43, Bristol
Brodsky, M. E., Northwestern '26, Bridgeport
Brody, B. S., Yale '28, New Haven
Brody, E. B., Harvard '44, New Haven
Bronson, W. T., University & Bellevue '98, Danbury
Brooks, D. L., Yale '47, Greenwich (New Haven County)
Brooks, P. L., McGill '32, Bridgeport
Brosnan, J. F., Tufts '30, New London
Brown, A. C., Woman's Med. Pa. '48, Middletown
Brown, A. S., Yale '26, Waterbury
Brown, C. R., Cornell '45, New Canaan
Brown, D. A., Long Island '46, Darien
Brown, D. S., Cornell '45, New Canaan
Brown, F. F., Jr., Columbia '40, Hartford
Brown, M. R. S., Temple '43, Meriden
Brown, P. H., Vermont '26, Stamford
Brown, P. N., Hahnemann '43, Meriden
Brown, R. J., Maryland '44, Stratford
Bruno, F. E., Tufts '40, Hartford
Bruno, J. J., Hahnemann '35, New Haven
Bruskin, C. E., Leipzig '32, Hartford
Buccheri, F. S., Tufts '35, New Britain
Bucciarelli, J. A., Temple '31, Norwalk
Buck, B. J., Harvard '26, Hartford
Buckhout, G. A., Tufts '35, Bridgeport
Buckley, J. L., Tufts '40, Torrington
Buckley, J. W., Georgetown '33, Bridgeport
Buckley, R. C., Yale '24, Hartford
Buckley, W. E., Boston '33, Middletown
Buckman, R. F., Long Island '45, Milford
Buda, G. E., Zurich '37, Bridgeport
Bullen, B. W., Jr., Cornell '41, Greenwich
Bullen, H. G., Pennsylvania '41, Stamford
Bumstead, J. H., Johns Hopkins '23, New Haven
Bunce, J. M., Yale '42 Hartford
Bunnell, W. W., Yale '29, Farmington
Bunting, H., Harvard '36, New Haven
Buol, R. S., Harvard '23, New Britain
Burack, J. O., Tufts '39, South Norwalk
Burbank, J., Harvard '43, Meriden
Burgdorf, A. L., Rush '31, Bloomfield
Burke, F. H., Georgetown '31, Rockville
Burke, J. F., Yale '31, Waterbury
Burness, S. H., Vermont '38, Hartford
Burnett, C. A., Jr., Cornell '43, Bristol
Burnham, B. A., Tufts '34, Waterbury
Burnie, C. A., Yale '35, Danbury
Burns, B. J., Georgetown '18, Bridgeport
Burns, F. M., Columbia '39, Shelton
Burns, G. D., Yale '25, Derby
Burns, J. E., Tufts '40, Hartford
Burns, M. M., Texas '27, West Hartford
Butler, N. G., Tufts '24, Hartford
Butterfield, W. L., Jr., Harvard '41, Hartford
Byrne, D. W., Columbia '27, Hartford

Cacace, V. A., Loyola '39, Bridgeport
Calabresi, M., Florence '26, Pine Orchard, Branford
Caldwell, D. M., McGill '19, South Manchester
Calef, B., St. Louis '32, Elmwood
Calhoun, H. A. Tufts '34, Higganum

Calio, J. V., Stanford '46, Hartford
Callahan, J. L., Georgetown '45, New Britain
Callahan, J. W., P. & S., Balt. '11, Norwich
Callender, E. F., Yale '12, Chester
Calverley, E. T., Woman's Med. Pa. '08, Hartford
Calvin, C. V., Harvard '16, Bridgeport
Camarda, A. L., Naples '41, Bridgeport
Cammann, O. DeN., Columbia '33, New Canaan
Campbell, H. B., Pennsylvania '09, Norwich
Campbell, R. H., Wayne '35, Hartford
Campbell, S., Vermont '23, Wallingford
Canby, J. E., Jefferson '27, West Hartford
Caney, W .H., Albany '41, Watertown
Canfield, N., Michigan '29, New Haven
Caniff, J. C., Cornell '43, Torrington
Canzonetti, A. J., Chicago '44, New Britain
Capacelatro, A., Tufts '19, New Haven
Caplan, H., Yale '27, Meriden
Caplan, M., Louisville '33, Meriden
Capobianco, A. P., N. Y. Med. Coll. '40, Bridgeport
Cappelletti, A. J., Jefferson '46, Waterbury
Cappiello, S., Tufts '19, Hartford
Carangelo, J., Tufts '38, Hartford
Carbone, H. A., Rochester '43, Norwich
Carbone, W. C., Georgetown '33, Hamden
Cardone, M. J., Vermont '37, Bridgeport
Carelli, G. F., Yale '11, New Haven
Carey, T. B., Albany '44, Norwich
Carey, T. C., Yale '28, Hartford
Carey, W. C., Columbia '33, Meriden
Carignan. R. Z., Georgetown '40, East Hartford
Carlson, C. E., Maryland '37, New Britain
Carniglia, E. F., Harvard '29, Hartford
Carpenter, R. M., Loyola '16, Stamford
Carpentieri, A. L., N. Y. Med. Coll. '38, Waterbury
Carpinella, M. J., Rochester '32, Branford
Carroll, G. J. Georgetown '44, Norwich
Carroll, J. E., Boston '25, Hartford
Carroll, P. R., Jr., Georgetown '29, Bridgeport
Carroll, W. E., Dartmouth '14, Orange, N. J. (New Haven County)
Carrozzella, J. C., Long Island '28, Wallingford
Carson, J. P., Yale '41, West Hartford
Carter, E. B., Johns Hopkins '11, West Hartford
Carter, G., Johns Hopkins '28, Greenwich
Carter, G. H., Columbia '35, Willimantic
Carter, M. G., Harvard '41, New Haven
Cartland, J. E., Jr., Columbia '43, Hartford
Carvey, E. V., Yale '35, Wethersfield
Carwin, J. L., Meharry '32, Stamford
Cary, J. M., Western Reserve '45, Middletown
Casagrande, J. J., St. Louis '32, Ansonia
Case, E. P., Michigan, '11, West Hartford
Case-Downer, M., Boston '29, Hartford
Caserta, S. J., Georgetown '37, Bridgeport
Cashman, J. L., Hahnemann '37, North Haven
Cassone, R., Vermont '41, Stamford
Castagno, M. M., Boston '43, Hartford
Castagno, R. A., Columbia '41, Hartford
Castaldo, L. F., Tufts '37, Bridgeport
Castiglione, F. M., N. Y. Med. Coll. '42, New Haven
Castro, R. P., Havana '45, Danbury
Catalan, J. O., Meharry '19, New Haven
Caulfield, E. J., Johns Hopkins '20, Hartford
Cavaliere, V. J., N. Y. U. '43, Bridgeport
Cavalieri, R. J., Jefferson '42, Newington
Celentano, L. E. H., Hahnemann '30, New Haven
Cenci, V. P., Tufts '29, Hartford
Cerrone, L. J., Bologna '38, New Haven
Chait, S. A., Nebraska '40, Torrington
Chapnick, M. H., Jefferson '32, Putnam
Chartier, G. M., Boston '33, Danielson
Chase, A. A., Harvard '01, Plainfield
Chase, C. C., Vermont '24, Middletown
Chasnoff, J. A., Long Island '36, West Haven
Chaucer, N. G., Columbia '41, Hartford
Cheney, C. B., Yale '41, New Haven
Cheney, G. P., Md. Coll. Med. '13, New London
Cheney, M. L., Vermont '17, Bridgeport
Chernaik, S. J., Jefferson '16, New Britain
Chernoff, H. M., N. Y. U. '43, New Haven
Cherry, J. B., McGill '43, Danbury
Chester, L. L., Vermont '38, Hartford
Chick, F. B., N. Y. Med. Coll. '46, Bridgeport
Chiffelle, T. L., Johns Hopkins '43, Albuquerque, New Mexico (New Haven County)
Chiota, J. A., Vermont '37, Bridgeport
Chobian, J. A., Loyola, '33, Seymour
Chotkowski, L. A., Yale '42, Kensington
Christine, B. W., Albany '48, Torrington
Churchill, J. A., Pennsylvania '45, Hartford
Ciccarelli, A. W., Hahnemann '42, Jamaica, L. I., N. Y. (Hartford County)
Cipriano, A. P., Long Island '41. New Haven
Claffey, M. F., Vermont '14, Bristol
Claiborn, L. N., Washington '27, New Haven
Claps, L. V., N. Y. U. '40, Greenwich
Clark, B. B, Cornell '37, New Britain
Clark, M. H., Women's Medical '33, New Haven
Clark, W. T., Queen's '34, Bridgeport
Clarke, C. C., Yale '32, New Haven
Clarke, H. M., Rochester '39, New Britain
Clarke, W. I., Harvard '41, Meriden
Clason, F. P., Harvard '15, Hartford
Cleary, H. J., Tufts '29, Waterbury (New Haven County)
Clement, D. H., Harvard '35, New Haven
Clifford, J. C., McGill '43, Hartford
Clifford, M. L., Colorado '33, Hartford
Cliffton, E. E., Yale '37, New Haven
Clifton, H. C., Pennsylvania '01, West Hartford
Climo, S., Ohio '29, New Haven
Cloonan, J. J., Georgetown '40, Stamford
Close, J. F., Columbia '25, Greenwich
Clow, H. L., Tufts '14, Newtown
Coates, S. P., Maryland '34, Suffield
Cobey, J. F., Yale '16, New Haven
Cody, G. R., Georgetown '36, Norwalk
Cody, T. P., Long Island '36, New Canaan
Coffin, S. F., Jr., Rochester '43, Oxford, England (Fairfield County)
Cofrances, L. W., Jefferson '23, New Haven
Cogan, G. E., Georgetown '23, Hartford
Cognetta, A. B., N. Y. U. '46, Stamford
Cognetta, J. J., Vermont '36, Stamford
Cogswell, E. S., Harvard '12, Hartford
Cogswell, L. P., Harvard '33, Hartford
Cohart, E. M., Columbia '33, New Haven
Cohen, B., Albany '42, Hartford
Cohen, D. J., Yale '32, Meriden
Cohen, L. H., Yale '31, New Haven
Cohen, W., Yale '23, New Haven
Cohn, S. H., Boston '34, Hartford
Colbert, J. W., Columbia '45, New Haven
Colburn, R. F., Vermont '37, Stamford
Cole, C. H., Yale '32, Waterbury
Cole, M. J., St. Bartholomew's '39, Hartford
Coleman, J. V., Vienna '34, New Haven
Collier, F. C., Yale '46, Cleveland, Ohio (Windham County)

Collins, J. O., Baylor '29, Waterbury
Collins, W. F., Yale '04, New Haven
Colmers, R. A., Vienna '37, Stamford
Colmore, J. P., Columbia '46, Noroton Heights
Colwell, H. S., Johns Hopkins, '14, New Haven
Combes, J. DeR., Long Island '17, Salisbury
Comfort, C. W., Jr., Yale '11, New Haven
Compson, F. E. M., Boston '20, Middletown
Comstock, E. R., Tufts '33, New London
Conforti, V. P., Duke '40, Torrington
Conklin, C. S., Fordham '16, Bridgeport
Conklin, C. T.. Jr., Vermont '41, Thomaston
Conlon, W. L., Jefferson '36, Boston, Mass. (Hartford County)
Connolly, A. J., Georgetown '28, New Haven
Connolly, J. P., Georgetown, '36, Stamford
Connor, G. J., Rochester '39, New Haven
Connor, G. M., Boston '35, Plantsville
Connor, J. J., Yale '30, Hartford
Connors, E. R., Boston '31, Bridgeport
Conroy, M. J., Yale '20, Meriden
Conte, H. A., Long Island '12, New Haven
Conte, M. G., Naples '35, New Haven
Conway, D. F., Jr., Columbia '37, New Haven
Conway, E. J., Yale '44, Hartford
Conway, F. M., Cornell '28, Danbury
Cook, G. F., Tufts '23, Plainville
Coombs, H. S., Tufts '45, New Canaan
Cooper, R. W., Vermont '50, Waterbury
Coppeto, C. J., Marquette '39, Waterbury
Coppola, E. A., Long Island '10, Waterford
Coral, M., Vienna '39, Terryville
Corbett, H. J., Tufts '29, Waterbury
Corbett, W. T., Hahnemann '42, Long Hill
Corcoran, M. A., Tufts '30, Hartford
Corey, W. VanA., George Washington '33, Hamden
Cornelio, F. J., Georgetown '34, Winsted
Cornfield, E., Women's Medical '43, New Britain
Cornwell, P. M., Yale '34, Hartford
Corradino, C. L., Tufts '29, New Haven
Corridon, J. D., Georgetown '28, South Norwalk
Corwin, D. B., Syracuse '32, Norwalk
Corwin, H. R., Long Island '42, Norwalk
Coshak, M., Boston '37, Waterbury
Costanzo, J. J., Illinois '05, Stamford
Costello, H. N., Johns Hopkins '10, Madison (Hartford County)
Cottiero, T., Yale '26, Waterbury
Couch, F. H., Yale '30, Cromwell
Couch, M. W., Minnesota '27, Cromwell
Couture, A. J., Boston '32, Moosup
Covalt, N. K., Indiana '33, Rocky Hill
Cox, M. E., Cincinnati '36, Waterbury
Cox, R. B., McGill '02, Collinsville
Coyle, B. J., Georgetown '18, Windsor Locks
Cozzolino, E. N., Harvard '33, West Haven
Craig, G. M., Harvard '20, Middletown
Craighill, M. D., Johns Hopkins '24, New Haven
Cramer, S. L., N. Y. Medical '41, Hartford
Crampton, C. B., Yale '37, Middletown
Crandall, B. B., Wisconsin '34, Mystic
Crane, J. E., Vermont '39, Springdale
Crawford, G., Harvard '38, Centerbrook
Crawley, G. A., Temple '28, West Hartford
Creadick, A. N., Pennsylvania '08, Rocky Hill (New Haven County)
Creaturo, N. E., Boston '31, Bridgeport
Crispin, M. A., Temple '41, Hartford (Fairfield County)
Crohn, E. B., Buffalo '43, Kent
Crosby, E. H., Yale '28, Hartford
Cullen, J. R., Georgetown '36, Hartford
Culotta, C. S., Yale '28, New Haven
Cunningham, R. D. M., Yale '30, Stamford
Curley, W. H., Cornell '08, Bridgeport
Curley, W. H., Jr., Cornell '38, Bridgeport
Curnen, E. C., Jr., Harvard '35, North Carolina (New Haven County)
Curran, H. J., Tufts '24, Waterbury
Curran, P. J., Columbia '01, Bridgeport
Curran, T. L., Boston U. '39, Hartford
Curtis, A. K., Tufts '05, East Hartford
Curtis, B. H., Columbia '36, Hartford
Curtis, W. B., Columbia '34, New Haven
Cusanelli, G. N., Long Island '46, New Haven
Cushman, G. L., Tufts '43, North Woodbury
Cushman, L. A., Harvard '24, West Hartford
Cusnir, M., Frankfurt '36, Meriden
Cutler, H. S., St. Louis '37, New Haven

D'Alessio, C. M., Maryland '37, New Haven
Daley, L. W., McGill '30, New Britain
Dallas, M., Boston '22, New Haven
Dalmain, W. A., St. Louis '37, Bristol
Dalton, G. H., Yale '12, New Britain
Daly, C. W., P. & S., Balt. '10, Hartford
Daly, J. E., Tufts '44, Waterbury
Daly, W. P., Georgetown '17, Hartford
D'Ambruoso, D. C., Columbia '36, Derby
Damiani, R. A., Tufts '33, Waterbury
D'Amico, J., Rome '37, New Haven
D'Amico, M., Yale '31, New Haven
Danaher, T. J., Yale '28, Torrington
D'Andrea, F. H., Yale '29, Stamford
D'Angelo, A. J., Rome '42, Southington
D'Angelo, E. J., Rome '42, Southington
Danyliw, J. M. Jefferson '47, East Hartford
Darrow, D. C., Johns Hopkins '20, New Haven
Darrow, J. E., Tufts '28, New Britain
Dautrich, A. W., Yale '39, Litchfield
Davey, L. M., Yale '43, New Haven (Hartford County)
Davie, R. N., Louisiana '44, Waterbury
Davis, D. A., Hahnemann '36, Derby
Davis, G. B., Vermont '24, Norwalk
Davis, J. B., Kansas '33, New Haven
Davis, J. E., Johns Hopkins '19, Hartford
Davis, J. S., Boston U. '39, South Norwalk
Davis, K. K., Virginia '43, New London
Davis, R. W., Jr., Yale '43 Hartford
Davis, T. F., Tufts '21, Fairfield
Davol, R. T., Columbia '41, Greenwich
Day, H. L., Yale '34, St. Albans, N. Y. (New Haven County)
Day, M. B., Virginia '40, Hartford
Day, R. S., New York '06, New Milford
Dayton, A. B., Johns Hopkins '15, New Haven
Dayton, C. J., Temple '47, Cheshire
Dayton, N. A., Ohio '15, Mansfield Depot (Windham County)
Dayton, T. R., Harvard '25, Rutland Heights, Mass. (New Haven County)
Dean, M. A., Tufts '43, Bridgeport
Dean, P. M., Columbia '44, Greenwich
Dean, S. R., Michigan '34, Stamford
DeAngelis, L., Virginia '36, New London
DeBonis, D. A., Naples '90, Hartford
deCholnoky, T., Budapest '28, Greenwich
DeCristoforo, R., Tufts '37, Waterbury
deForest, G. K., Yale '32, New Haven
DeKlyn, W. B., Temple '41, Danbury

de la Vergne, P. M., McGill '35, Meriden
Delevett, A. F., Johns Hopkins '40, Bridgeport
Delgado-Fourzan, Enrique, Mexico '43, Hartford
Delgrego, A. L., George Washington '30, New Haven
D'Elia, P. F., Tufts '44, New Haven
Della Pietra, A., Georgetown '41, Hartford
Delligan, F. W., Georgetown '41, Hartford
Delohery, C. L., Temple '26, Danbury
DeLuca, H. R., George Washington '16, Bridgeport
DeLuca, J. V., Georgetown '47, Bridgeport
DelVecchio, L. F., Georgetown '31, Bridgeport
Deming, A. S., Harvard '40, Hartford
Deming, C. D., Johns Hopkins '10, Hartford
Deming, C. K., Columbia '17, New Haven
Deming, C. L., Yale '15, New Haven
Deming, E. A., Johns Hopkins '08, West Hartford
Deming, E. G., Harvard '40, Hartford
Denne, T. H., Vermont '05, West Hartford
Dennehy, W. J., Yale '18, New Haven
Denton, G. D., Queens '28, Canton
DePasquale, F. L., Pennsylvania '26, Hartford
DePasquale, J. A., Pennsylvania '36, Hartford
Deren, M. D., Syracuse '33, Bridgeport
Derkach, S. L., Hahnemann '40, Greenwich
DeRosa, S. F., Jefferson '24, Meriden
Desmond, C. T., Boston U. '38, Hartford
Desmond, W. F., Yale '25, Newtown
D'Esopo, J. N., McGill '31, New Haven
de Suto-Nagy, I. K., Royal Hung. '15, New Haven
Detora, A. M., Boston '40, Stafford Springs
Deutsch, J. V., Long Island '36, Southbury
Devenis, M. M., Yale '19, Waterbury
DeVito, M. J., Vanderbilt '28, Hartford
Devitt, E. K., Maryland '07, Old Lyme
DeWitt, F. N., Pennsylvania '17, Bridgeport
Dey, F. L., Northwestern '44, Niantic
Deyoe, D. H., Albany '33, Durham, New Hampshire (Hartford County)
Diamond, E. H., Breslau '32, Norwalk
DiBlanda, H. A., N. Y. Medical '32, Weston
Dichter, C. L., Md. Coll. Med. '05, Stamford
Dichter, I. S., Jefferson '31, Stamford
Dickenson, J. R., Pittsburgh '44, Westport
Dickinson, F. McL., Columbia '05, Rockville
Dickinson, G. H., Vermont '46, Meriden
Dickinson, M. M., Columbia '38, Watertown
DiFrancesco, L. P., Tufts '31, Stamford
DiGiandomenico, A. T., St. Louis '41, Meriden
Dignam, B. S., Yale '35, Thompsonville
Dillon, J. H., Yale '04, Waterbury
DiLorenzo, A. T., Georgetown '41, Waterbury
DiLorenzo, S. F., Tufts '43, Waterbury
Dinan, H. P., Tufts '38, Stratford
Dinolt, R., Vienna '30, Putnam
Dion, A. J., Tufts '28, Hartford
Dion, J. A., Georgetown '37, Hartford
Dionne, U. A., Tufts '30, Waterbury
Diskan, A. E., Temple '37, Manchester
Diters, E. N., Tennessee '48, Collinsville
Dixon, H. C., Bowdoin '17, Norwich
Dobbins, J. M., Jr., N. Y. Med. Coll. '50, Stamford
Dobbs, W. G. H., Rochester '34, Torrington
Dodd, B., Columbia '33, Hartford
Doe, T. A., Yale '46, Springfield, Mass. (New Haven County)
Doerr, W. J., Erlangen '40, Hartford
Donadeo, J., Bologna '42, Elizabeth, N. J. (Fairfield County)
Donnelly, J., Liverpool '38, Hartford
Donnelly, S. P., Georgetown '24, New Britain
Donnelly, W. A., Cornell '40, Bridgeport
Donnelly, W. A., Vermont '34, Hartford
Donner, S., Cornell '33, Hartford
Donohue, J. D., Baltimore '09, Uncasville
Donohue, J. J., P. & S., Balt. '96, Norwich
Donohue, S. M., Tufts '48, Wilson
Donovan, W. F., Boston '31, Hartford
Dorfman, J., Graz '37, West Hartford
Dorian, E., Maryland '37, New Britain
Dorian, G. D., Hahnemann '39, New Britain
Dorion, R. H., Vermont '32, Stamford
Douglass, F. L., Long Island '16, Groton
Douglass, W. C., Long Island '08, Madison
Downie, G. R., Yale '48, Winsted
Downs, E. F., Johns Hopkins '37, Bronxville, N. Y. (Litchfield County)
Dray, E. J., Jefferson '09, New Britain
Dreher, A. C., Yale '23, Waterbury
Dreher, S. M., Temple '37, Derby
Driscoll, J. J., Vermont '25, Danbury
Drobnes, S., Freiburg '37, Norwich
DuBois, F. S., Rush '31, New Canaan
DuBois, R. L., Maryland '35, Waterbury
Dudac, T. W., Georgetown '33, Southington
Duennebier, H. W., Tufts '40, Niantic
Duffy, L. T., Tufts '34, Hartford
Duffy, V. P., Maryland '17, Grafton, W. Va. (New Haven County)
Duffy, W. C., Johns Hopkins '14, New Haven
Duksa, W. J., Georgetown '37, Hartford
Dundee, J. C., Queens Univ., Belfast '23, Wallingford
Dunn, M. L., N. Y. U. '43, New Britain
Dunne, E. P., Maryland '18, Unionville
Dunphy, D., Yale '44, Stratford
Dunsmore, R. H., Hahnemann '43, Hartford
Durkee, R. E., Jr., Harvard '36, Hartford
Dushane, J. E., Tufts '36, Hartford
Duzmati, P. P., Jefferson '36, Bridgeport
Dwyer, C. E., Georgetown '25, Waterbury
Dwyer, H. L., Jr., Northwestern '43, New Haven
Dwyer, P. J., University & Bellevue '97, Waterbury
Dyer, C. E., Tufts '28, New London
Dzubaty, M., Buffalo '48, West Haven

Earle, B. B., Rush '30, Glastonbury
Ebers, T. M., Nebraska '31, Hartford
Eckert, G. R., Tufts '33, Danbury
Eddy, M. H., Harvard '35, Bridgeport
Edelberg, E. K., Buffalo '44, Simsbury
Edelberg, H., Buffalo '44, Simsbury
Edlin, C., Tufts '25, Waterbury
Edmonstone, W. M., Rochester '43, Mystic
Edson, D. H., Vermont '42, Danbury
Edson, R. C., Jefferson '31, West Hartford
Edson, R. H., Cornell '35, Shelton
Edwards, L. E., George Washington '47, Bridgeport
Egan, J. R., Duke '42, Old Saybrook
Egee, J. B., Hahnemann '34, Newtown
Eilbergas, M., Zurich '41, Windsor Locks
Eimas, A., Tufts '30, Bridgeport
Eisenberg, S. E., Rochester '39, New Britain
Elgosin, R. B., McGill '40, Hamden
Eliot, M. M., Johns Hopkins '18, Washington, D. C. (New Haven County)
Elliot, K. G., Tufts '26, Hartford
Elliott, F. G., Jr., Howard '40, Bridgeport
Elliott, J. R., Boston '32, Canaan
Ellis, L. G., Jefferson '20, Hartford
Ellis, W. A., Jefferson '40, Hartford

Ellison, F. S., Yale '34, Hartford
Ellison, M. M., Rochester '43, New London
Ellrich, D. L., Jefferson '28, Westport
Ely, J. G., Harvard '23, Lyme
Ematrudo, F. R., Eclectic, Cinn. '21, Hamden
Emmett, F. A., Yale '02, Hartford
Englehart, E. E., Strassburg '17, Hartford
Epstein, B., Vienna '36, Danbury
Epstein, C. J., Yale '29, New Haven
Epstein, E. J., N. Y. Med. Coll. '45, Stamford
Epstein, J. I., Yale '43, Portland
Erba, S. M., Hahnemann '45, New Haven
Errico, L., Yale '21, New Haven
Erslev, A. J., Copenhagen '45, New Haven
Eskwith, I. S., Syracuse '40, Bridgeport
Esposito, J. J., Columbia '37, Bridgeport
Etkind, M. G., Maryland '33, New Haven
Evans, A. S., Buffalo '43, New Haven
Evans, T. S., Columbia '21, New Haven
Evarts, J., Columbia '29, Cornwall Bridge
Eveleth, M. S., Johns Hopkins '38, New Haven

Fabricant, M. W., Hahnemann '39, New London
Fabricant, S. E., Jefferson '19, Waterbury
Fabro, J. A., Tufts '37, Torrington
Fagan, F. J., Boston '38, New London
Fagan, F. X., Cornell '33, Hartford
Fairlie, C. W., Jr., Columbia '41, West Hartford
Fakkel, M. J., Tufts '50, Stamford
Farland, V. L., Montreal '25, Hartford
Farrell, J. R., Long Island '47, Stamford
Farrell, R. F., Vermont '42, Stamford
Fasanella, R. M., Yale '43, New Haven
Fawcett, G. G., Cornell '15, South Norwalk
Fay, W. J., Harvard '14, Hartford
Feeney, T. M., Boston '36, Hartford
Fekety, S. H., Tufts '30, Middletown
Felder, E. A., Jefferson '48, Darien
Felding, H. A., Hahnemann '31, Stamford
Felt, P. R., Dartmouth '10, East Hampton
Felty, A. R., Johns Hopkins '20, Hartford
Fenney, P. W., Tufts '31, Ft. Howard, Maryland (New Haven County)
Ferguson, H. K., N. Y. U. '32, New London
Ferguson, J. F., Jr., Yale '40, Wallingford
Ferguson, R. C., Yale '20, Rockville
Ferrara, M., Marquette '35, Norwich
Ferrucci, J. C., Tufts '48, Bridgeport
Filer, H. L., Jr., Yale '46, New Haven
Filson, R. M., Queen's '15, West Hartford
Fincke, C. L., Harvard '28, Stamford
Findorak, F. G., Georgetown '37, Bridgeport
Fine, B., Jefferson '32, Stamford
Fine, J., Pennsylvania '31, Stamford
Finesilver, E. M., Johns Hopkins '24, Hartford
Fink, L., Leipzig '23, Bridgeport
Finkelstein, W., Harvard '34, Waterbury
Finkelstone, B. B., P. & S., Balt. '10, Bridgeport
Finley, G. C., Tufts '24, Hartford
Finn, A. J., Bowdoin '21, Waterbury
Finn, E. J., Yale '10, Shelton
Finn, F. W., Columbia '38, Greenwich
Fiorito, J. A., Washington '37, New Haven
Fischer, A., Paris '36, Hamden
Fischer, W. J. H., Yale '11, Milford
Fisher, J. G., Paris '11, Cannes (A.M.) France (Fairfield County)
Fisher, J. W., Woman's Med. Pa. '93, Middletown
Fisher, R. L., Columbia '40, Sharon
Fiske, M., Boston '27, Stamford
Fiskio, P. W., Yale '27, New Haven
Fitts, F. C., Tufts '37, New Haven
Fitzpatrick, E. E., Maryland '15, Waterbury
Fitzpatrick, E. J., McGill '42, New Haven
Fitzpatrick, W. F., Cornell '38, Norwalk
FitzSimons, E. F., Tufts '24, New Haven
Flaherty C. V., Yale '10, Hartford
Flaherty, J. E., Georgetown '08, Rockville
Flaherty, M. V., Georgetown '43, Hartford
Flanagan, E. D., St. Louis '35, South Norwalk
Fleish, M. C., Tufts '40, Hartford
Fleisher, P., Western Ontario '44, Bridgeport
Flynn, C. T., Yale '11, New Haven
Flynn, C. T., Jr., Yale '43, Meriden
Flynn, E. J., Long Island '43, South Norwalk
Flynn, F. J., Virginia '43, Hartford
Flynn, H. A., Yale '27, New Haven
Flynn, H. L., Vermont '29, Mansfield Depot, (Windham County)
Flynn, J. B., Jefferson '44, Meriden
Flynn, W. H., Maryland '16, Bristol
Fogel, D. H., Duke '38, Stamford
Foley, F. X., Boston '34, Bridgeport
Foohey, F. C., Laval '43, Hartford
Foord, A., Columbia '41, Baltimore, Md. (New Haven County)
Foord, E., Yale '47, New Haven
Foote, C. J., Harvard '87, New Haven
Ford, A. P., Woman's Med. Pa. '04, New Haven
Foret, J. H., Louisiana '39, Virgin Islands, U. S. A. (Fairfield County)
Forman, J. B., Yale '39, New Haven
Fortier, N. L., McGill '43, Hartford
Foster, E. W., Harvard '24, Meriden
Foster, H. J., Hahnemann '43, Berlin
Foster, J. H., Pennsylvania '17, Waterbury
Foster, L. C., Harvard '23, New Haven
Fowler, G. A., Columbia '40, Sharon
Fowler, R. N., Columbia '34, Mystic
Fox, G. F., Vermont '37, West Hartford
Fox, G. G., Harvard '34, Meriden
Fox, J. C., Jr., Johns Hopkins '20, Hartford
Fox, R. A., Creighton '37, Norwalk
Franco, J. E., Tufts '40, Hartford
Frank, H. S., Columbia '24, Middletown
Freedman, B. P., Yale '20, New Haven
Freedman, L. Z., Tufts '44, New Haven
Freedman, M., Tufts '32, New Haven
Freeman, D., Yale '24, New Haven
Freeman, J. J., Temple '33, Newington
Freeman, W. K., Cornell '24, Greenwich
Freiheit, J. M., Yale '27, Waterbury
Friedberg, I. H., Tufts '37, Newington
Friedberg, S., Long Island '28, Stamford
Friedman, I., George Washington '31, Colchester
Friedman, I., Yale '33, New Haven
Friedman, N. H., Tufts '33, Stratford
Friedman, S., Boston '31, Newtown
Friend, A. E., Queen's '22, South Manchester
Friery, C. M., Boston '29, Hartford
Friou, G. J., Cornell '44, Newington (New Haven County)
Fritz, J., Vienna '15, Hartford
Frost, L. H., Vermont '13, Plainville
Frothingham, J. G., Harvard '35, New Canaan
Fry, C. C., Northwestern '24, New Haven
Fuhrmann, J. M., Long Island '43, East Hartford (New Haven County)
Fuldner, R. V., Columbia '33, New Haven
Furniss, H. W., Howard '91, Hartford
Furniss, W. E., Tufts '40, Bristol

Gaberman, D., Columbia '20, Hartford
Gade, C. J., Yale '10, Bridgeport
Gaetz, T. H., McGill '24, Shelton
Gaffney, C. B., Loyola '30, Bridgeport
Gaffney, J. J., Loyola '30, Danbury
Gager, J. J., Tufts '42, New London
Gaines, N. D., Illinois '41, Hartford
Galen, J. H., Long Island '42, Ansonia
Galinsky, D., Tufts '35, Hartford
Gallivan, J. N., Tufts '35, East Hartford
Gallo, F., Jefferson '34, Winsted
Gancher, J., Long Island '06, Waterbury
Gandy, R. A., Virginia '27, Stamford
Gandy, R. R., Pennsylvania '99, Stamford
Ganey, J. M., Columbia '04, New London
Ganey, J. M., Jr., Boston '45, New London
Garbelnick, D. A., Boston '17, Bridgeport
Garcin, C. R., McGill '25, Danielson
Gardner, C. W., Maryland '01, Bridgeport
Gardner, H. T., Yale '41, Upton, Long Island, N. Y. (New Haven County)
Gardner, N. H., Tufts '34, East Hampton
Gardner, S. M., Colorado '32, Bridgeport
Gardy, L. A., Bologna '37, Hartford
Garland, R. B., P. & S., Balt. '13, Hartford
Garlick, G. B., Yale '12, Bridgeport
Garofalo, M. L., Naples '35, New Haven
Garston, L. E., St. Louis '30, Torrington
Gaylord, C. W., Yale '15, Branford
Geanuracos, G. J., Long Island '44, Bridgeport
Gedeon, P. E., Beirut '45, Oxford
Geer, W. A., Yale '34, Bridgeport
Geetter, I. S., Jefferson '29, Hartford
Geib, H. A., Univ. & Bellevue '14, Milford
Geiger, A. J., Harvard '30, New Haven
Gencarelli, A. F., Buffalo '39, New Haven
Genovese, F. T., N. Y. U. '29, Danbury
Genovese, S., Cornell '11, Danbury
Gens, J. P., Yale '37, Norwalk
Gentile, A. L., Boston '29, New Haven
Genvert, H., Yale '36, Norwalk
Geraci, L. A., Columbia '17, Rocky Hill
German, W. J., Harvard '26, New Haven
Gerow, G. H., Toronto '24, Westport
Gesell, A., Yale '15, New Haven
Gettings, J. A., Jefferson '16, New Haven
Gevalt, F. C., Jr., Columbia '40, Sharon
Giamarino, H. J., Maine '06, New Haven
Giannotti, C. C. Albany '18, West Haven
Giardi, L. P., Vermont '48, Hartford
Gibson, C. B., Atlanta '14, Meriden
Gibson, D. F., Yale '27, Danbury
Gibson, Fred, McGill '41, New Haven
Gibson, F. D., Syracuse '35, Hartford
Giddings, J. C., Vermont '43, Meriden
Giffin, L. A., Harvard '35, Hartford
Gilday, J. L., Eclectic, Cinn. '13, Bridgeport
Gildea, M. A., Buffalo '24, Bridgeport
Gildersleeve, G. H., Yale '23, Norwich
Giles, N. W., Vermont '21, Stamford
Gill, M. M., Chicago '38, New Haven
Gillespie, H., Jefferson '34, Hartford
Gillette, A. T., Cornell '08, Woodbury
Gillis, G. E., Tufts '37, North Haven
Gills, W. L., Johns Hopkins '12, West Hartford
Gillson, R. F., Vermont '29, New Haven
Gilman, R. L., Harvard '29, Storrs (Windham County)
Gilmer R. J., Meharry '42, New Haven
Gilmore, H. R., Yale '31, New Haven
Ginzler, A. M., Wayne '31, Bridgeport
Giobbe M. E., Tufts '29, Torrington
Giorgio, N. A., Long Island '25, Hartford
Gipstein, E., Jefferson '31, New London
Girouard, J. A., Baltimore '99, Willimantic
Giuffrida, F., Tufts '37, Meriden
Giuliano, L. A., Tufts '32, South Norwalk
Giuliano, S., Tufts '30, Hartford
Glaser, W., Tufts '38, New Haven
Glass, W. H., Duke '37, Hartford
Glass, W. I., Cornell '38, Bridgeport
Glaubman, H. M., Yale '27, Hartford
Glaubman, W. A., Edinburgh '38, Warehouse Point (Tolland County)
Glazer, M., Tulane '22, New Haven
Glazier, J. R., Harvard '22, West Hartford
Glenn, W. W. L., Jefferson '38, New Haven
Glike, F. P., Yale '41, Meriden
Gloetzner, H. J., Temple '41, Norwalk
Goade, W. J., Jr., Harvard '44, Boston, Mass. (New Haven County)
Godfrey, E. W., Pennsylvania '37, Hartford
Godfried, M. S., Yale '36, New Haven
Goerner, J. R., Yale' 43, Watertown
Goetsch, J. B., Rochester '38, New Haven
Goff, C. W., Illinois '24, Hartford
Gold, J. D., Columbia '91, Bridgeport
Gold, L. H., N. Y. Med. '32, Hartford
Goldberg, I. S., Creighton '33, Torrington
Goldberg, S. J., Yale '07, New Haven
Goldberg, S. J., Jr., Harvard '36, New Haven
Goldenberg, J. J., Dalhousie '26, Hartford
Goldenthal, C., Yale '44, Hartford
Goldfarb, S. L., Milan '38, Stamford
Goldman, G., Yale '10, New Haven
Goldmeier, E., Frankfurt '39, Boston, Mass. (New London County)
Goldschmidt, M., Med. Coll. of Virginia '38, New Britain
Goldstein, M., Yale '24, New Haven
Goldstein, M. R., Hahnemann '43, Hartford
Goldstein, T., Yale '47, Hartford
Goldys, F. M., Tufts '26, Danbury
Golia, U. V., Long Island '45, New Haven
Golino, E. F., Rochester '36, Hartford
Golomb, E. F., Woman's Med. Pa. '38, Cleveland, Ohio (Fairfield County)
Golston, H., Med. Coll. of Virginia '26, Hartford
Gompertz, M. L., Columbia '37, New Haven
Gonzalez, L. D., Havana '43, Danbury
Good, P. S., Yale '45, Waterbury
Good, R. C., Columbia '42, Waterbury
Good, W. M., Yale '09, Waterbury
Goodchild, F. M., Columbia '18, Storrs (Windham County)
Goodell, R. A., Harvard '28, Hartford
Goodrich, A., Indiana '41, Bridgeport
Goodrich, F. W., Jr., McGill '41, New London
Goodrich, W. A., Columbia '35, Hartford
Goodrich, W. J., Albany '39, Bridgeport
Goodyer, A. V. N., Yale '42, New Haven
Gordon, W. F., Long Island '96, Danbury
Gordon, Y., Tufts '48, Hartford
Gorham, G. V., Michigan '30, Norwalk
Gorman, V. A., Cornell '42, Bridgeport
Gosselin, G. A., Vermont '15, Hartford
Gottesfeld, B. H., Colorado '39, Hartford
Gould, M. M., Tufts '31, Hartford
Gourlie, H. W., Harvard '31, Thompsonville
Grady, J. F., Columbia '32, New Haven
Granniss, I., Yale '96, Northford (Middlesex County)

Granoff, M. A., Chicago '37, New Haven
Grant, R. F., Albany '38, Cromwell
Gratz, C. M., Toronto '23, Greenwich
Grau, L. C., Dartmouth '12, Hartford
Gray, A. S., Univ. & Bellevue '15, Hartford
Gray, F. D., Jr., Columbia '43, New Haven
Gray, F. G., N. Y. Med. '44, New Haven
Gray, H. J., St. Louis '21, Hartford
Grayson, M., N. Y. Med. Coll. '41, New London
Green, F. C., Meharry '41, New Haven
Green, H. H., Johns Hopkins '31, South Norwalk
Green, J. H., Univ. & Bellevue '13, Waterbury
Green, R. H., Johns Hopkins '38, New Haven
Green, W. F., Harvard '32, Newtown
Greenberg, A., Long Island '32, Old Saybrook
Greenblatt, H. J., Vermont '36, New Britain
Greenblatt, J., Louisiana '39, Stamford
Greene, G. S., Harvard '39, Hartford
Greenhouse, B., Yale '21, New Haven
Greenhouse, H. R., N. Y. Med. Coll. '44, Hamden
Greenspun, D. S., Yale '25, Bridgeport
Greiner, G. F., Vanderbilt '40, Kent
Grendon, D. A., Harvard '28, Kent
Grenon, O. A., Georgetown '33, East Haven
Grevatt, K. L., Pennsylvania '35, Redding
Griffin, D. P., Jefferson '14, Bridgeport
Griffith, B. H., Yale '48, New York (New London County)
Grigas, J. E. Tufts '36, Greenwich
Griggs, J. B., Yale '26, Hartford
Grillo, V. J., Yale '33, New Haven
Grillo, W., Rochester '38, Waterbury
Griswold, A. S., Yale '21, Bridgeport
Griswold, C., Yale '24, Bridgeport
Griswold, D., Columbia '43, Hartford
Griswold, E. M., Yale '32, Glastonbury
Griswold, M. H., Vermont '13, Hartford
Griswold, M. T., Tufts '05, Harwinton
Groark, J. A., Yale '24, New Haven
Groark, O. J., Med. Chi. Phila. '16, Bridgeport
Grodin, H. W., Yale '17, New Haven
Grosskreutz, D. C., Illinois '42, New Haven
Grossman, J. H., Rochester '41, Bridgeport
Grossmann, W., Berlin '21, Hartford
Grower, J. H., Nebraska '25, Middletown
Gualtieri, M. V., Tufts '43, Waterbury
Gudernatch, G. S., Cornell '39, Sharon
Guida, F. P., Yale '34, New Haven
Gulash, J. R., Marquette '40, Bridgeport
Gulino, A. J., Tufts '31, Plainfield
Gundling, C. A., Cincinnati '43, Windsor
Gura, G. M., Loyola '31, Southington
Gurwitz, J., Tufts '38, Hartford
Gushee, E. S., Harvard '03, Wallingford
Guss, L., Oklahoma '41, Norwich
Guttman, T., Prague '39, Bridgeport

Haberlin, C. E., Med. Coll. Va., '24 Stratford
Haddad, F. M., Yale '43, Ansonia
Haine, J. W., Albany '43, Stamford
Haines, H. L., Johns Hopkins '39, New London
Haines, R. W., Jefferson '46, Hartford
Hainsworth, W. C., Virginia '40, Willimantic
Hale, F., Columbia '09, Bridgeport
Hale, V. A., Texas '22, Gales Ferry
Haley, J. C., Yale '40, New Haven
Haliday, E. G., Queen's '27, Stonington
Hall, L., Harvard '24, Hartford
Hall, M. I., Edinburgh '34, Bristol
Hall, M. N., Albany '48, Clinton
Hall, R. W., Yale '07, Trumbull
Hall, W. C., Pennsylvania '30, Hartford
Hall, W. E., Yale '25, Meriden
Halloran, J. V., Boston '36, Greenwich
Hamblet, J. B., McGill '40, Manchester
Hamlin, C. H., Harvard '41, Hartford
Hampton, L. J., Pennsylvania '33, New Haven
Hanaghan, J. A., Harvard '41, Shelton (Hartford County)
Hanchett, H. B., Jefferson '05, Torrington
Hankin, M. A., Long Island '33, New Haven
Hanley, J. B., Jefferson '39, Bristol
Hanley, J. L., Jr., Yale '35, Bridgeport
Hanley, J. P., Cornell '06, Stafford Springs
Hanrahan, W. R., P. & S., Balt. '05, Bristol
Hansell, R. J., Ohio '32, Wilmington, Delaware (Fairfield County)
Hansen, W. H., N. Y. Med. Coll. '46, Shelton
Hanson, M. C., Rush '23, New Haven
Hardenbergh, D. B., Harvard '34, Bridgeport
Hardt, G. W., Nebraska '41, Byram
Harris, A. L., Long Island '14, Essex
Harris, B. R., Yale '22, New Haven
Harris, H. P., Jr., Duke '36, Fairfield
Harris, J. S., Yale '32, New Haven
Harris, L. D., Tufts '34, Hartford
Harrison, E. R., Yale '26, New Haven
Harrison, F. M., Jefferson '22, Stamford
Harshbarger, I. L., Virginia '22, Bridgeport
Hart, B. I., Columbia '04, Bridgeport
Hart, C. J., Hahnemann '03, New Britain
Hart, J. C., Yale '30, New Haven
Hart, J. G., Long Island '41, Westport
Hart, R. W., Cornell '45, New Haven
Hartman, F. B., Harvard '34, New London
Harty, J. E., Georgetown '37, Waterbury
Harvey, C. C., Cornell '16, Middletown
Harvey, D. F., Yale '33, Hartford
Harvey, E. R., Baltimore '09, Seymour
Harvey, E. R., Jr., Yale '37, Seymour
Harvey, S. C., Yale '11, New Haven
Harvey, S. W., Cornell '46, Middletown
Harvey, T. S., Yale '41, Philadelphia, Penn. (New Haven County)
Harwood, C. W., Vermont '40, Middletown
Harwood, P. H., Jr., Harvard '39, Bridgeport
Hastings, L. P., Vermont '23, Hartford
Hathaway, J. S., Harvard '28, New Haven
Havey, L. A., Vermont '10, Bridgeport
Hawley, K. J., Yale '44, Waterbury
Hawthorne, J., Tulane '20, Greenwich
Haydock, G. G., Harvard '45, Sharon
Haylett, H. B., Vermont '07, East Hartford
Hazen, D. R., Harvard '33, Hartford
Hazen, R., Vermont '98, Thomaston
Heafey, J. R., Syracuse '34, South Norwalk
Healy, T. M., Columbia '41, Manchester
Hebard, G. W., Cornell '36, New Canaan
Heinemann, M., Goettingen '25, New Haven
Helfrick, F. W., Johns Hopkins '41, Manchester
Helfrick, Sylvia, Johns Hopkins '44, Manchester
Hellijas, C. S., Rochester '41, Wethersfield
Hendel, I., Jefferson '17, New London
Hendricks, A. L., Yale '07, New Haven
Henkle, R. T., Cornell '31, New London
Hennessey, J. G., Tufts '34, Bridgeport
Hennessy, J. J., Columbia '26, Hartford
Henze, C. W., Yale '00, New Haven
Hepburn, R. H., Harvard '39, Hartford
Hepburn, T. N., Johns Hopkins '05, Hartford

Herman, R. S., Jr., Buffalo '46, East Hartford
Herr, H. H., Tufts '49, Guilford
Herrmann, A. E., Harvard '23, Waterbury
Hersey, T. F., Tufts '37. New Haven
Hershey, D. D., Albany '50, Bristol
Hershman, H. H., Western Ontario '41, Bristol
Hertzberg, R. F., Harvard '26, Stamford
Hervey, Z. P., Vienna '38, East Hartford
Hess, O. W., Buffalo '31, New Haven
Hetrick, L. E., Hahnemann '98, Hampton
Hetzel, J. L., Yale '26, Waterbury
Heublein, G. W., Yale 34, Hartford
Hewes, C. T., Vermont '31, Groton
Heyer, H.H., N. Y. U. '87, New London
Heyman, J., Med. Coll. Va. '17, Hartford
Hickcox, C. B., Tufts '38, Hartford
Hiden, R. B., Virginia '23, New Canaan
Higgins, H. G., Cornell '33, Milford
Higgins, H. W., Tufts '32, Norwich
Higgins, J. J., Georgetown '28, New Haven
Higgins, V. W., Long Island '25, Essex
Hill, E. R., Jefferson '24, Mystic
Hill, W. E., Bowdoin '21, Naugatuck
Hillman, M. M., Columbia '19, New Haven
Hills, L. H., Woman's Med. Pa. '96, Winter Haven, Fla. (Windham County)
Hinchey, R. J., Tufts '21, Waterbury
Hirata, I., Yale '12, New Haven
Hirschfeld, O. M., Tufts '31, Hartford
Hirshberg, M. S., Tufts '27, Hartford
Hitchins, C. S., Cornell '38, New Haven
Hockmuth, L. N., Tufts '42, Hartford
Hodgkins, C. H., Hahnemann '36, New Haven
Hoffman, C. C., Buffalo '16, Hartford
Hoffman, J., N. Y. U. '44, Columbus, Ohio (Fairfield County)
Hoffman, J. B., Columbia '43, Greenwich
Hogan, W. L., Vermont '18, Hartford
Holley, E., Albany '96, East Hampton
Hollinshead, J. B., Yale '37, West Hartford
Holtz, R. S., Vermont '28, Hartford
Hooper, G. H., Boston '29, Bridgeport
Hopper, J. M., Chicago '40, Hartford
Horgan, J. D., N. Y. Med. Coll. '45, Dallas, Texas (Hartford County)
Horn, B., N. Y. U. '29, Bridgeport
Horning, B. G., Harvard '28, Battle Creek, Mich. (Hartford County)
Horowitz, I., Vienna '37 Bridgeport
Horsefield, T. E., Vermont '29, Moodus
Horton, F. H., Yale '47, Manchester
Horton, W. H., Boston '40, Windsor
Hough, P. S., Meharry '44, Middletown
Hough, P. T., McGill '32, Hartford
Houle, R. T., Georgetown '32, East Hartford
Houze, H. G., Queens '24, Westport
Howard, A. J., Yale '20, New Haven
Howard, H. A., Tufts '29, Wethersfield
Howard, J. H., Georgetown '18, Bridgeport
Howard, L. A., Louisiana '39, Cos Cob
Howard, L. K., Minnesota '29, Hartford
Howard, M. E., Johns Hopkins '31, New Haven
Howard, W. O., N. Y. U. '32, Tuskegee, Ala. (New Haven County)
Howe, E. R., Columbia '46, Hartford
Howe, G. E., Harvard '18, Hartford
Howlett, K. S., Vanderbilt '31, Shelton
Howorth, B. M., Washington '25, Stamford
Hubert, G. R., Yale '35, Torrington
Hudon, F. A., Pennsylvania '37, Bristol
Humpage, N. W., Tufts '36, Torrington
Hunkemeier, E., N. Y. U. '33, South Norwalk
Hunter, R., Columbia '43, Hartford
Huntington, F. S., Harvard '24, Darien
Hurlbutt, F. R., Jr., Yale '43, Greenwich
Hurwitz, A., Johns Hopkins '33, Newington
Hurwitz, G. H., Maryland '33, Hartford
Huss, J. H., Cornell '42, Greenwich
Huss, K. S., Columbia '44, Greenwich
Hutchison, J. E., Johns Hopkins '14, Hartford
Huvelle, C. H., N. Y. U. '43, Torrington
Hyde, C. E., Yale '10, St. Petersburg, Florida (Fairfield County)
Hymovich, L., Jefferson '29, Stamford
Hynes, F. H., Tufts '13, New Haven

Iannotti, J. P., Naples '38, Plainville
Igersheimer, W. W., Tufts '44, New Haven
Ignace, S. J., Georgetown '30, Ansonia
Impellitteri, T. J., Marquette '49, Stratford
Ingenito, G. A., Maryland '43, New Haven
Inkster, J. H., Cornell '30, Ridgefield
Intriere, A. D., Michigan '44, Greenwich
Ippolito, T. L., N. Y. Med. Coll. '38, Norwalk
Ireland, R. M., Vermont '31, New Milford (Fairfield County)
Irvin, J. S., Columbia '12, New Britain
Irving, J. G., Toronto '32, Hartford
Irwin, H. H., Tufts '34, New London
Isenman, R., Tufts '30, Westport
Ives, E. B., Tufts '42, Bridgeport

Jack, J. L., Yale '23, North Haven
Jackson, A. F., Howard '22, Hartford
Jackson, A. H., Yale '24 Waterbury (Litchfield County)
Jackson, A. J., Columbia '15, Waterbury
Jackson, E. B., Johns Hopkins '21, New Haven
Jacobson, C. E., Jr., Cornell '35, Hartford
Jaffe, S. A., N. Y. U. '38, New Haven
Jaiven, S. J., N. Y. U. '40, Stamford
James, A. G. B., McGill '27, Bridgeport
James, G. R., Yale '10, Hamden
James, L. P., Yale '27, Hartford
James, W. R., Yale '44, Essex
January, D. A., Yale '34, Hartford
January, M. H., Yale '35, West Hartford
Janzen, A. H., Kansas '38, New Haven
Jarrett, W. A., Harvard '34, Newtown
Jarvis, H. G., Johns Hopkins '10, West Hartford
Jenkins, R. H., Med. Coll. Va. '16, New Haven
Jennes, M. L., Tufts '38, Waterbury
Jennes, S. W., Tufts '34, Waterbury
Jennings, W. F., Rush '37, Hartford
Jenovese, J. F., Pennsylvania '30, West Hartford
Johnson, A. A., Columbia '17, Waterbury
Johnson, C. E., Harvard '26, New Haven
Johnson, C. W., Boston '45, Thompsonville
Johnson, H. A., Vermont '25, Watertown (New Haven County)
Johnson, J. C., Jr., Vanderbilt '44, Hartford
Johnson, P., Tufts '32, Hartford
Johnson, R. D., Iowa '38, New Britain
Johnson, W. H. N., Jr., Howard '39, Norwalk
Johnston, E. H., Maryland '00, Waterbury
Jones, E. K., Columbia '34, Bridgeport
Jones, F. S., Yale '28, Hartford
Jones, J. F., Columbia '43, Danielson
Jones, M. B., N. Y. U. '41, South Norwalk
Jordan, R. H., Virginia '33, New Haven

Joseph, C., Long Island '46, Torrington
Joseph, L. G., Jefferson '39, New Haven
Josephs, W. W., Georgetown '30, New Haven
Joslin, S. L., Yale '43, Fairfield
Joyce, W. M., Jefferson '17, Middletown

Kalaman, F. J., Georgetown '41, Norwalk
Kalett, J., Jefferson '28, New Britain
Kalin, J. I., Harvard '24, Hartford
Kalman, E., Royal Elizabeth U., Hungary '23, Bridgeport
Kaplan, H., N. Y. Med. Coll. '44, New Britain
Kaplan, L., Baylor '36, Bridgeport
Kardys, F. J., George Washington '42, Hartford
Kardys, J. A., George Washington '30, Hartford
Karlin, F. L., St. Andrews '34, Waterbury
Karotkin, R. H., N. Y. U. '32, Hartford
Karpe, R., Prague '24, Hartford
Karpel, S., Maryland '36, New London
Kartin, B. L., Columbia '39, New Haven
Kaschmann, J., Munich '22, Hartford
Katz, D., Vermont '25, Hartford
Katz, H., Harvard '21, Hartford
Katz, H. W. Tufts '40, New Haven
Katz, I., N. Y. Med. Coll. '37, Meriden
Katz, M. E., Oklahoma '41, Norwich
Katzenstein, R. E., Berne '38, Meriden (Middlesex County)
Katzin, B., Johns Hopkins '43, Torrington
Katzman, S. S., Jefferson '21, Hartford
Kaufman, C., Jefferson '19, New London
Kaufman, M., Johns Hopkins '43, Bridgeport
Kaufman, W., Michigan '38, Bridgeport
Kausel, H. W., Yale '44, New Haven
Kay, R., Temple '45, Hartford
Kazanjian, N. A., Hahnemann '45, New Haven
Kearney, M. W., Jr., Harvard '40, Hartford
Keddy, R. A., McGill '24, Stamford
Keefe, G. G., Maryland '22, Hartford
Keefe, R. S., Boston '25, Hartford
Keefe, W. J., Maryland '31, Hartford
Keegan, D. F., Maryland '21, Bridgeport
Keeney, R. R., Jr., Tufts '34, Manchester
Keet, J. E., Long Island '47, Hartford
Keith, A. R., Harvard '03, Hartford
Kelemen, E., Budapest '25, Camanillo, Calif. (Fairfield County)
Keller, F., Long Island '43, New Haven
Kelley, N. R., Harvard '37, Windsor
Kelley, W. O., Johns Hopkins '37, Norwich
Kellogg, H. K. W., Columbia '03, Norwalk
Kelly, C. C., Johns Hopkins '14, Hartford
Kelly, J. C., Queen's '28, Old Greenwich
Kelly, L. C., Cornell '29, Waterbury
Kemler, R. L., Yale '43, Hartford
Kemp, E. P., Tufts '25, Fairfield
Kemp, W. W., Harvard '39, Stamford
Kendall, R. E., Johns Hopkins '21, Hartford
Kenigsberg, N., Yale '39, Bridgeport
Kennedy, C. S., Georgetown '30, Naugatuck
Kennedy, J. J., Jr., Boston '46, Windsor Locks (New Haven County)
Kennedy, S. R., Jr., Buffalo '44, Torrington
Kennedy, W. C., Georgetown '10, Middletown (Litchfield County)
Kent, E. H., N. Y. U. '43, Stamford
Kertesz, J., Vienna '24, New Haven
Kessler, F., Vienna '37, West Haven
Kettle, R. H., Queen's '28, Norwich
Keys, R. C., Kansas '27, South Norwalk
Kezel, A. P. C., Georgetown '35, Stamford
Kidney, J. J., Jefferson '43, Toledo, Ohio (Middlesex County)
Kilbourn, A., Yale '23, Hartford
Kilbourn, J. B., P. & S., Balt. '11, Hartford
Kilgus, J. F., Maryland '31, Hartford (Litchfield County)
Kinder, F. S., Cornell '38, Bridgeport
Kingman, J. H., Columbia '85, New Haven (Middlesex County)
Kingsbury, I. W., Columbia '03, West Hartford
Kinney, K. K., Iowa '21, Willimantic
Kirby, S. B., Yale '28, New Haven
Kirchner, J. A., Virginia '40, New Haven
Kirsch, N., Long Island '40, Hartford
Kirschbaum, E. H., Yale '12, Waterbury
Kitchen, B. F., Jr., Yale '46, New Haven
Klatskin, G., Cornell '33, New Haven
Klebanoff, H. E., Yale '25, New Haven
Klein, A. A., Louisville '29, Hartford
Klein, H., Michigan '40, New Haven
Klein, H. T., Illinois '40, Stamford
Klein, J., Long Island '34, Hartford
Klein, R. H., Women's Med. Coll. Pa. '40, West Hartford
Kleiner, S. B., Yale '15, New Haven
Kleinman, H. L., Buffalo '41, Bridgeport
Klumpp, T. G., Harvard '28, New York City (New Haven County)
Knapp, C. S., Columbia '19, Greenwich
Knapp, C. W., Columbia '12, Newtown
Knapp, R. P., Columbia '11, Manchester
Knauth, M. S., Columbia '23, Wilton
Kneale, H. B., Johns Hopkins '20, Bridgeport
Knight, H. C., Tulane '33, Middletown
Knoff, W. F., Syracuse '45, Hartford
Koffler, A., Jefferson '34, Stamford
Kogut, H. V., N. Y. Med. Coll. '43, Bridgeport
Koleshko, L. J., Maryland '42, Waterbury
Konopka, F. J., Georgetown '31, Wallingford
Korab, J. J., Tufts '43, Middletown
Korn, F. E., N. Y. Med. Coll. '50, Durham
Kornblut, A., N. Y. U. '20, Bridgeport
Koster, L. W., N. Y. U. '37, West Haven
Kott, J. H., N. Y. U. '33, Torrington
Koufman, W. B., Tufts '35, New Haven
Krall, I. H., Long Island '37, Hartford
Kraszewski, H. W., Tufts '38, New Britain
Krinsky, C. M., Tufts '33, New London
Krochmal, H., Vienna '37, Meriden
Kroeger, H. H., Rush '32, Pittsburgh, Pa. (New Haven County)
Krosnick, G., Jefferson '38, New Haven
Krosnick, M. Y., Yale '30, New Haven
Kueffner, W. R., Minnesota '43, Fairfield
Kummer, A. J., Harvard '39, New Haven
Kummer, S. I., Hahnemann '49, Rockville
Kunkel, F. E., Yale '26, Hartford
Kunkel, P., Washington '34, Newington
Kurtz, I. M., N. Y. Med. Coll. '33, Ridgefield
Kushlan, S. D., Yale '35, New Haven
Kussner, S. F., N. Y. Med. Coll. '47, Milford
Kyle, G. B., Long Island '38, Sandy Hook

Laakso, A. O., Cornell '37, Danielson
La Bella, L. O., Columbia '25, Middletown
Labensky, A., Yale '21, New London
LaBrecque, F. C., Tufts '35, Waterbury
Lacava, J. J., Georgetown '34, New Britain
Lach, F. E., Maryland '41, New Haven
LaFemina, N. F., Long Island '25, New Haven
Lahey, W. J., Harvard '42, Hartford

Lambert, H. B., Jefferson '09, Rocky Hill (Fairfield County)
Lampson, E. R., Columbia '96, Hartford
Lampson, R. S., Harvard '34, Hartford
Landecker, N., Friedrich Wilhelm '26, Bridgeport
Landry, A. B., Jefferson '09, Hartford
Landry, B. B., Harvard '20, Hartford
Lane, W. Z., Columbia '42, Darien
Lang, W. P., Hahnemann '01, North Haven
Langner, H. P., Yale '22, Milford
Lankin, J. J., Harvard '37, Hartford
Lanman, J. T., Yale '43, Stamford
Lapenta, R. G., George Washington '37, Hartford
LaPierre, A. R., Columbia '38, Norwich
LaPierre, W. W., Columbia '39, Norwich
LaPlume, A. A., Montreal '24, Bristol
LaPorte, T. F. V., Boston '33, Bristol
Laramore, H. F., Texas '27, Hartford
Larkin, C. L., Yale '15, Waterbury
Larrabee, J. W., Harvard '26, Hartford
Larson, A. L., Albany '35, Hartford
Lasser, L. M., Indiana '45, Hartford
Laszlo, A., Kiel '23, Bridgeport
LaTaif, C. G., Hahnemann '36, New Milford
Latimer, M. L., Vanderbilt '32, New Haven
Lavietes, P. H., Yale '30, New Haven
Lavorgna, M. H., St. Louis '40, New Haven
Lawrason, F. D., Minnesota '45, Washington, D. C. (New Haven County)
Lawton, R. J., Md. Coll. Med. '08, Terryville
Layton, W. M., Jr., Western Reserve '46, Stamford
Leak, R. L., Albany '98, West Hartford
Lear, H. A., St. Louis '43, Hartford
Lear, M., Yale '11, New Haven
Leary, D. C., Yale '36, Willimantic
Leavy, S. A., Rochester '40, New Haven
Lebhar, N. F., Columbia '39, Westport
Lechausse, R. M., Med. Coll. of Va. '35, Manchester
Leddy, P. A., Harvard '24, Orono, Maine (New Haven County)
Lee, F. N., Kansas '23, Milford
Lee, J. F., Cornell '46, Greenwich
Lee, J. R., Queen's '24, Devon
Lee, W., Yale '41, New Britain
Lehmus, H. J., N. Y. U. '43, Manchester
Lencz, E., Vienna '36, Ansonia
Lenehan, J. R., Jefferson '37, Hartford
Lengyel, P., Budapest '31, Bridgeport
Lenkowski, W. J., N. Y. U. '37, Waterbury
Lennox, M. A., Yale '39, New Haven
Lenoci, R. J., Hahnemann '40, Boston, Mass. (Fairfield County)
Leo, F. J., Marquette '46, East Hartford
Leonard, G. A., Md. Coll. Med. '05, Big Spring, Texas (New Haven County)
Leonard, J. C., Yale '32, Hartford
Leonard, M., Yale '31, New Haven
Leone, F., Long Island '32, Danbury
Lesko, J. M., Duke '38, Bridgeport
Levenson, A., Tufts '22, Bridgeport
Levin, A. E., Tufts '30, Hartford
Levin, H. A., Univ. & Bellevue '18, New Haven
Levin, R. R., Harvard '36, Hartford
Levine, A. I., New York Univ. '35, Newington (Fairfield County)
Levine, H., Harvard '41, New Britain
Levine, H. P., Vermont '50, Stamford
Levine, J., Vermont '50, Stamford
Levine, S. S., P. & S., Balt. '12, Hartford
Levinsky, A., Alabama '20, Bridgeport
Levinsky, M., Maryland '28, Bridgeport
Levy, A., Tufts '31, Winsted
Levy, D. F., Yale '19, New Haven
Levy, M. N., Tufts '23, Bridgeport
Levy, N., Yale '27, Branford
Levy, S. H., Tufts '35, Stratford
Lewicki, E. S., Georgetown '35, Waterbury
Lewis, H. D., Harvard '42, New Haven
Lewis, R. M., Pennsylvania '10, New Haven
Lewis, S. D., George Washington '31, Hartford
L'Heureux, J. A., Boston '34, Meriden
Liberson, M., Paris '34, Hartford
Liberson, W. T., Paris '36, Hartford
Lieben, Jan, Liverpool '43, Hartford
Lieberman, D. L., N. Y. U. '26, Chester
Lieberthal, M. M., N. Y. U. '35, Bridgeport
Liebow, A. A., Yale '35, New Haven
Lillian, M., Georgetown '44, New Haven
Linder, J. H., Columbia '27, Sharon
Lindsay, M. S., Tufts '11, Middletown
Lindskog, G. E., Harvard '28, New Haven
Lipkoff, C. J., N. Y. U. '36, Milford
Lirot, S. L. R., McGill '32, Meriden
Lischner, M. D., Yale '30, Hartford
Litter, L., Basel '36, Hartford
Little, D. M., Jr., Harvard '44, Stamford
Little, H. C., Yale '10, New Haven
Little, M. F., Yale '28, Hartford
Little, M. H., Harvard '35, Willimantic
Little, O. A. G., Boston '35, Willimantic
Littwin, R. J., Long Island '36, Bristol
Livingston, W. T., Pennsylvania '43, New Britain
Lobb, R. A., Hahnemann '37, Deep River
Locke, H. L. F., Tufts '12, Hartford
Lockhart, R. H., Yale '28, Bridgeport
Locks, M. O., Cornell '43, Westport
Lockward, H. J., Western Reserve '43, Manchester
Lockwood, H. DeF., Yale '01, Meriden
Lockwood, J., Johns Hopkins '30, Greenwich
Loffredo, L., Pennsylvania '22, Middletown
Loftus, J. F., Georgetown '48, Hartford
Logan, W. J., Yale '25, New Haven
Lohman, W. H., Cornell '45, East Hartford
Lohrmann, W., Rochester '43, Meriden
Loiacono, A. J., Harvard '27, New London
Loiacono, R. A., N. Y. Med. Coll. '43, New London
Lolli, G., Rome '28, New Haven
Lombardi, P. F., Tufts '21, Waterbury
Longo, A. D., Georgetown '38, Portland
Longo, V. F., Long Island '43, Forestville
Longworth, E. F., N. Y. Med. Coll. '37, Norwalk
Lonsdale, H. G., Berlin '22, North Little Rock, Arkansas (Hartford County)
Lopatin, C., Louisville '41, Bridgeport
Lord, B. J., Jr., Cornell '43, Norwich
LoRusso, D. L., Marquette '34, Torrington
Losito, A. J., St. Louis '38, Cos Cob
Louderbough, H., Vermont '38, Watertown
Lovallo, F., Tufts '44, Torrington
Lovelace, T. R., Howard '30, Waterbury
Loveland, E. K., Yale '97, Watertown
LoVetere, A. A., George Washington '35, New Britain
Lowell, W. H., Jr., Harvard '37, Hartford
Lowenberg, R. I., N. Y. U. '42, New Haven
Lowman, R. M., Maryland '36, New Haven
Lubchansky, J. H., N. Y. U. '33, New London
Lublin, R. D., Johns Hopkins '29, East Hartford
Luby, T. J., McGill '14, Hartford
Luciano, M. C., Pennsylvania '44, Bridgeport

Luckner, W. G., Jefferson '38, Stafford Springs
Ludlow, G. C., Harvard '19, New Canaan
Lukoski, W. A., Georgetown '32, Waterford
Lundberg, G. A. F., Jefferson, '19, South Manchester
Lundborg, F. L., Yale '30, West Hartford
Luria, S., Western Ontario '38, Bridgeport
Lydon, L. G. M., Yale '40, New Haven
Lyddy, J. R.. N. Y. U. '44, Bridgeport
Lyman, D. R., Virginia '99, Wallingford
Lynch, E. J., Pennsylvania '09, Shelton
Lynch, F., Columbia '43, Westport
Lynch, H., N. Y. U. '24, Bridgeport
Lynch, J. C., N. Y. U. '86, Bridgeport
Lynch, R. J., Bellevue '97, Bridgeport
Lynch, V. A., Jefferson '38, Bridgeport
Lyon, G. A., Cornell '41, Bridgeport
Lyon, H. P., McGill '36, Harkel, Liberia, West Africa (Hartford County)
Lyons, B. E., Yale '38, Norwalk
Lyons, W. B., Georgetown '45, Torrington

MacCready, P. B., Johns Hopkins '21, New Haven
MacCready, W. H., Harvard '27, Windsor
MacDougall, A. D., Corneli '43, Groton
Mack, A. G., Albany '43, Bridgeport
Mackay, W. D., Indiana '28, Sharon
MacKee, G. M., New York Med. Coll. '99, Stamford
MacLean, E. M., McGill '30, Farmington
MacLeod, E. A., Wom. Med. Coll. Pa. '25, Niantic
Madden, L. I., Harvard '10, Avon
Magnano, J., Yale '27, Middletown
Magyar, S. P., Laval '43, New Haven
Maher, J. R., Boston '27, Stratford
Mahoney, D. F. C., Georgetown '24, Redlands, Calif. (Hartford County)
Mahoney, J. J., McGill '33, Norwich
Maidman, L., N. Y. U. '40, Wilton
Mainer, R. G., Vermont '39, New Britain
Maiorano, J. F., Jr., N. Y. Med. Coll. '43, New Haven
Maislen, S., Vermont '14, Hartford
Major, J. W., Vanderbilt '39, Willimantic
Malloy, E. F., Cornell '28, Stamford
Malone, E. H., Boston '43, Amityville, N. Y. (Fairfield County)
Malone, R. F., Tufts '43, Devon
Mancall, I. T., Pennsylvania '44, Hartford
Mancinelli, M. J., Hahnemann '43, Stamford
Mancoll, M. M., Jefferson '28, Hartford
Mandell, M., Long Island '46, South Norwalk
Mandi, G., Vienna '32, Bethel
Manjoney, V. A., Vermont '47, Bridgeport
Mann, N. M., Long Island '45, Hartford
Manwaring, I. J., Pennsylvania '95, Norwich
Marglis, B., Bowdoin '20, Bridgeport
Margold, A. M., Vermont '25, Norwalk
Margolick, M., McGill '35, Putnam
Margolius, N., Cornell '33, Waterbury
Marinaro, N. A., St. Louis '30, Hartford
Marino, F. S., Maryland '42, Hartford
Marino, R. S., Boston '42, Bristol
Marinoff, P. A., Rome '41, Milford
Markley, D. N., Edinburgh '36 ,West Hartford
Markley, H. E., Yale '43, Greenwich
Markley, L. L., Prague '25, Bridgeport
Markoff, A., Long Island '32, New Haven
Marks, B. E., N. Y. U. '30, Pueblo, Colorado (Middlesex County)
Markwald, H. W., Berlin '37, New Hartford
Marranzini, S., N. Y. U. '28, Hartford
Marsh, A., St. Andrews '37, Hartford
Marsh, A. D., Yale '08, Hampton
Marsh, E. J., Yale '44, New Haven
Marsh, F., Bologna '37, Manchester
Marshak, I. J., Tufts '26, New Haven
Marshall, C. L., Howard '24, New Haven
Martelon, G. F., Boston '48, Bridgeport
Martin, E., Yale '40, New Britain
Martin, J. E., Dalhousie '42, Norwich
Martin, J. G., Yale '33, West Hartford
Martin, R. A., Vermont '37, Bridgeport
Martin, S. J., Wisconsin '35, Hartford
Marvin, H. M., Harvard '18, New Haven
Maslak, R., Louisville '34, Warehouse Point
Massa, A. F., Yale '18, New Haven
Massaro, J., Yale '45, Manchester
Massey, D. M., Hahnemann '36, Bridgeport
Mast, G. W., Tennessee '31, Stamford
Mastrangelo, A., Jr., Boston '39, Stamford
Mastroianni, L., Padua '17, New Haven
Mastronarde, N. A., Yale '32, Hartford
Mather, C. B., Jefferson '25, Greenwich
Matossian, N. Y., Southern California '43, New Haven
Matteis, J. T., Yale '26, New Britain
Maurer, L. L., Yale '16, New Haven
Maurer, W. S., Yale '38, Willimantic
Maxwell, J. A., Med. Coll. Va. '17, Bridgeport
Mayo, E. R., Tufts '38, Waterbury
McAlenney, P. F., Yale '29, New Haven
McCarthy, F. W., Jr., Columbia '42, Hartford
McClellan, W. E., Toronto '04, Hartford
McCrann, D. J., Tufts '34, Hartford
McCreery, E. P., Jr., Virginia '42, Bridgeport
McCue, M. P., Harvard '34, Hartford
McDermott, J. F., Cornell '23, Hartford
McDonald, H. T., Jr., N. Y. Med. Coll. '50, Darien
McDonell, R. R., Jefferson '45, New Haven
McFarland, F. W., Vermont '28, Stamford
McFarland, W. J., Yale '39, New London
McGaughey, J. D., Jefferson '10, Wallingford
McGaughey, J. D., III, Jefferson '44, Wallingford
McGourty, A. F., N. Y. Homeo. '18, Stamford
McGourty, D. P., Jefferson '27, Stamford
McGovern, E. F., Univ. & Bellevue '01, Bridgeport
McGrath, J. F., McGill '23, Hartford
McGrath, J. H., Yale '08, Waterbury
McGuire, F. J., Boston '37, Guilford
McIlroy, P. T., Queens '16, Danbury
McIntyre, F. P., Vermont '42, Stamford
McKeon, J. J., Hahnemann '39, Hamden
McKnight, R. S., Pittsburgh '45, West Hartford
McLarney, T. J., P. & S., Balt. '97, Hartford (New Haven County)
McLean, C. E., Yale '45, Kenmore, N. Y. (New Haven County)
McLean, J. J., Tufts '20, Melbourne, Florida (Hartford County)
McLean, T. S., Jr., Vermont '34, Bridgeport
McLellan, P. G., Harvard '25, Hartford
McLeod, C. E., Vermont '34, Middletown
McMahon, F. C., Fordham '19, Stamford
McMahon, G. W., Tufts '37, New Britain
McMahon, J. D., Creighton '37, South Norwalk
McMahon, W. H., Jr., Fordham '20, South Norwalk
McNamara, A. P., George Washington '41, Bridgeport
McNulty, T. F., Georgetown '32, Hartford
McPherson, S. R., Jefferson '44, Hartford
McQueen, A. S., Yale '01, Branford
McQueeney, A. M., Yale '05, Bridgeport

Meacham, C. T., Pennsylvania '30, Stamford
Medbury, S. E., Yale '43, Willimantic
Meeker, D. O., Rochester '29, Riverside
Meigs, J. W., Harvard '40, New Haven
Meister, L. F., Long Island '30, Falls Village
Mekrut, J. A., St. Louis '31, Meriden
Mellion, J., Yale '23, New Britain
Meltzer, S. B., Long Island '44, Bridgeport
Mendelsohn, W., Johns Hopkins '33, New Haven
Mendillo, A. J., Yale '07, New Haven
Mendillo, J. C. F., Yale '30, New Haven
Menousek, J. A., Vermont '32, Plainville
Meo, R. C., George Washington '34, Waterbury
Merriman, H., Columbia '36, Waterbury
Merriman, M. H., Columbia '06, Waterbury
Meschter, E. F., Med. Chi. Phila. '98, Stamford
Meshken, J., Rush '37, Bridgeport
Messina, M. C., Tennessee '27, Wethersfield
Messinger, H. J., Basel '39, Fairfield
Metcalf, E. H., Jefferson '14, Rockville
Meunier, J. L., Vermont '38, New Milford (Fairfield County)
Meyer, F. M., Indiana '28, Bridgeport
Meyers, R. A., Michigan '31, Watertown
Mezey, C. M., Royal U. Budapest '18, Gulfport, Mississippi (New London County)
Michalowski, V. S., Boston '29, New Britain
Micheels, L. J., Utrecht '47, New Haven
Michel, L. I., Long Island '43, New Haven
Middlebrook, L. F., Johns Hopkins '30, Hartford
Mignone, J., Yale '33, New Haven
Milano, N. A., Georgetown '27, West Haven
Miles, H. S., Columbia '91, Bridgeport
Millen, S. R., George Washington '38, New Haven
Miller, G. R., Tufts '39, Manchester
Miller, H. B., Rush '33, Hartford
Miller, H. K., Columbia '32, Stamford
Miller, J. R., Johns Hopkins '11, West Hartford
Miller, R. M., Columbia '26, New Milford
Miller, S. M., Tulane '41, Hartford
Mills, B. L., Vermont '25, Meriden
Mills, C. W., Cornell '38, Norwalk
Minor, J. V., Jr., Georgetown '46, South Norwalk
Minor, L. W., Yale '32, Middletown
Mirabile, C. S., McGill '30, Hartford
Mirabile, T. J., Georgetown '37, East Hartford
Miselis, F. J., Boston '45, Uncasville
Missett, J. S., Columbia '40, Hartford
Misuk, J. F., Georgetown '32, Meriden
Mitchell, G. V., McGill '38, Torrington
Mlynarski, J. A., Georgetown '39, New Britain
Mogil, M., Buffalo '39, New Haven
Moher, J. J., Yale '37, Hartford
Molnar, G. J., Georgetown '43, Bridgeport
Monacella, J. M., Columbia '35, Windsor
Monagan, T. M., Harvard '40, Waterbury
Monahan, D. T., Yale '33, Bridgeport
Mongillo, F., Med. Coll. Va. '28, New Haven
Monti, L. J., Vermont '41, New Britain
Mooney, S., Tufts '27, Bridgeport
Moorad, P. J., Rochester '31, New Britain
Moore, C. D., Queen's '28, Stamford
Moore, D. B., Tufts '35, New Haven
Moore, G. E., Yale '34, Darien
Moore, H. F., Missouri '98, Bethel
Moore, M. R., Queen's '29, Norwich
Moore, W. J., Columbia '21, Cheshire
Morgan, K. R., Yale '42, Bridgeport
Morgan, W. O., Georgetown '30, Westport
Moriarty, J. P., Vermont '47, Stamford
Moriarty, M. E., Yale '26, South Manchester
Morrill, H. F., Harvard '25, Waterbury
Morris, F. R., Maryland '41, Bridgeport
Morris, J. S., Texas '27, Greenwich
Morrison, D. R., Cornell '39, Hartford
Morrison, D. W., Columbia '40, Manchester
Morrison, J. E., Maryland '46, Norwich
Morriss, W. H., Johns Hopkins '12, Wallingford
Morrissett, L. E., Med. Coll. Va.. '36, Greenwich
Morrissey, M. J., P. & S., Balt. '97, Hartford
Morrow, H. S., Columbia '40, Danbury (Litchfield County)
Morse, L. R., Queen's '26, Ontario, Canada (Hartford County)
Morse, W. J., Vermont '31, New London
Moser, D. W., Tufts '43, Rocky Hill
Moser, O. A., Yale '02, Rocky Hill
Moss, H. G., N. Y. U. '28, New Haven
Mott, F. E., Buffalo '41, New Haven
Moulyn, A. C., Utrecht '30, Darien
Mouradian, M. G., Wom. Med. Coll. Pa. '13, New Britain
Moxness, B. A., Georgetown '25, Washington, D. C. (Hartford County)
Moxon, G. F., Marquette '30, Mansfield Depot (Windham County)
Moyer, W. T., Jr., Pennsylvania '47, Manchester
Moylan, T. P., Buffalo '22, Hartford
Moyle, H. B., Toronto '10, Hartford
Mulaire, V. J., Boston '39, Stamford
Mulford, E. H., II, Duke '41, Stamford
Mullaney, T. P., Jr., Vermont '46, Windsor Locks
Mullen, J. J., Tufts '29, Waterbury
Mulligan, M., Boston '38, Waterbury
Mulville, M. F., Tufts '37, Hartford
Murcko, W. J., Marquette '37, Torrington
Murdock, C. L., N. Y. Med. Coll. '48, Bridgeport
Murdock, T. P., Maryland '10, Meriden
Murphy, C. A., Long Island '33, Stamford
Murphy, J., Pennsylvania '95, Middletown
Murphy, J. C., Columbia '32, Danbury
Murphy, J. J., Georgetown '35, Danbury
Murphy, J. J., Tufts '43, East Hartford
Murphy, O. L., Vermont '21, Simsbury
Murphy, R. D., Tufts '47, Wethersfield
Murphy, T. B., Harvard '23, Wallingford
Murphy, T. D., Columbia '30, Lowell, Mass. (Hartford County)
Murphy, T. F., Jefferson '33, West Hartford
Murray, H. J., Jefferson '16, Stamford
Murray, J. G., N. Y. U. '43, Greenwich
Murray, J. T., N. Y. U. '47, New London
Murray, T. O., Tufts '32, New Orleans, La. (Fairfield County)
Murray, W. J., Jefferson '32, Bridgeport
Musselman, L. K., Johns Hopkins '19, New Haven
Mylon, E., Berlin '20, New Haven

Nagle, W. T., Med. Chi. Phila. '14, Southington
Nagourney, D., Long Island '36, Bridgeport
Nahum, L. H., Yale '16, New Haven
Narowski, J. J., Tufts '43, Derby
Neff, W. E., Jr., Columbia '33, Cheshire
Neidlinger, W. J., Cornell '33, Hartford
Nelson, W. N., George Washington '26, Cromwell
Nelson, W. P., III, Cornell '44, Albany (New Haven County)
Nemoitin, B. O., Long Island '34, Stamford
Nemoitin, J., Columbia '05, Stamford
Nesbit, R. R., Albany '29, New Haven

Nespor, R. W., Boston '33, Westport
Nestos, P. A., Rush '14, Bristol
Nettleton, I. LaF., Long Island '98, Bridgeport
Neumann, H. A., Long Island '09, Bridgeport
Neuswanger, C. H., Harvard '23, Waterbury
Nevulis, A. V., Vermont '38, New Britain
Newcombe, R. V., Vermont '40, Willimantic
Newman, A. A., Long Island '42, Bridgeport
Newman, H. R., Toronto '35, New Haven
Newman, J. T., Yale '19, New Haven
Newman, R., Johns Hopkins '30, New Haven
Newton, L., N. Y. Homeo. '31, Bridgeport
Nichols, C. W., Vermont '20, Bridgeport
Nichols, E., Yale '39, Hartford
Nichols, F. L., Columbia '42, Hartford
Nichols, R. W., Johns Hopkins '12, New Haven
Nicholson, R. E., Tulane '42, Hartford
Nielsen, T. M., Copenhagen '38, New London
Noble, R. P., Columbia '40, Sharon
Nodelman, J., Yale '29, New Haven
Nolan, J. F., McGill '32, Bridgeport
Nolan, J. J., Pittsburgh '42, Stamford
Nolan, J. O'L., Tufts '40, Hartford
Norrington, E. G., N. Y. Med. Coll. '39, Norwalk
Northman, F. F., Breslau '34, Bridgeport
Northrop, R. A., Jefferson '32, Norwalk
Northrup, H. E., Woman's Medical '40, West Hartford
Nowrey, J. E., Johns Hopkins '22, Mansfield Depot (Windham County)
Nurnberger, J. I., Northwestern '43, Hartford

Oberg, F. T., Harvard '16, Bridgeport
O'Brasky, G. H., Jefferson '20, New Haven
O'Brasky, L., Jefferson '22, New Haven
O'Brien, H. R., Michigan '19, Washington, D. C. (Hartford County)
O'Brien, J. F., Yale '08, Waterford
O'Brien, J. M., Pennsylvania '37, Bridgeport
O'Brien, W. H. J., Yale '12, New Haven
O'Connell, E. B., Yale '41, New Haven
O'Connell, E. J., Tufts '34, Unionville
O'Connell, J. D., Harvard '39, Hartford
O'Connell, J. F., Vermont '21, Hartford
O'Connell, M. F., Yale '22, Hartford
O'Connell, P. H., Loyola '29, Norwich
O'Connell, W. M., Yale '17, West Haven
O'Connor, D. S., Bowdoin '19, New Haven
O'Donnell, T. J., Syracuse '08, Greenwich
Oelschlegel, H. C., Jefferson, '11, Torrington
Oesau, H. T., Jefferson '26, Stratford
Ogden, F. N., Columbia '42, Norwalk
Ogden, R. T., Harvard '24, Hartford
Ogilvie, J. B., Yale '34, Stamford
O'Keefe, D. F., Columbia '29, Hartford
Olmsted, J. G. M., McGill '25, Hartford
Olmsted, R. W., Harvard '44, Stratford
O'Looney, J. J., Jr., Jefferson '45, White River Junction, Vermont (Fairfield County)
Olore, L., Tufts '43, Waterbury
Olsavsky, J. C., Georgetown '43, Hyattsville, Maryland (Fairfield County)
Olsen, R. C., Long Island '45, New London
Oltman, J. E., Minnesota '34, Newtown
O'Meara, F. P., N. Y. Med. Coll. '36, Stamford
Onderdonk, H. J., Univ. & Bellevue '97, East Hartford
O'Neil, M. L., Yale '29, Jewett City
O'Neil, V. D., McGill '41, Newington
O'Neill, C. W., Yale '26, Hartford
O'Neill, J. J., Tufts '32, Bridgeport
Oppenheimer, K., Heidelberg '20, Norwich
Opper, L., Munich '33, Torrington
Orbach, E. J., Friedrich Wilhelm Univ., Berlin '24, New Britain
Orlowski, A. W., Tufts '36, Torrington
Oros, L. M., Budapest '37, Bridgeport
Orr, H. D., Boston '48, South Coventry (Windham County)
Osborn, S. H., Tufts '14, Hartford
Osgood, C., Columbia '03, Norwich
Osmond, R. H., Yale '23, Hartford
Oster, K. A., Cologne '34, Bridgeport
Otis, F. N., Tufts '18, Meriden
Otis, I. S., George Washington '17, Meriden
Ottenheimer, E. J., Virginia '22, Willimantic
Oughterson, A. W., Harvard '24, New Haven
Owens, A. P., McGill '37, Bridgeport
Owre, E. S., Long Island '45, New London
Oxnard, E. W., Harvard '36, Cheshire

Padula, R. D., Cincinnati '30, Norwalk
Padula, V. D., Rome '35, Hartford
Paget, J. F., Tufts '40, Bridgeport
Pagliaro, J. J., Georgetown '37, Shelton
Paladino, J. S., Boston '26, Hartford
Paley, M., Long Island '36, South Norwalk
Palmieri, M. L., Yale '32, Middletown
Palmieri, M. W., Naples '33, New Haven
Panettieri, A. J., Vermont '37, Bridgeport
Pantaleo, C. V., Creighton '43, New Haven
Paolillo, C. G., Yale '35, New Britain
Papa, J. S., Tufts '28, Bristol
Pappenheim, E., Vienna '35, New York City (New Haven County)
Parente, L., Emory '31, Hamden
Paris, M., N. Y. U. '30, South Norwalk
Parisi, A. J., Tufts '44, New Haven
Park, P. A., Iowa Homeo. '10, Fairfield (Hartford County)
Parker, R. L., Western Ontario '41, Bridgeport
Parkinson, J. E., Yale '48, New Haven
Parlato, H. A., N. Y. U. '36, New Britain
Parlato, M. A., Yale '08, Derby
Parmelee, B. M., Vermont '18, Bridgeport
Parrella, G. S., Yale '41, Milford
Parrella, L. A., Tufts '34, North Haven
Parshley, P. F., Pennsylvania '27, West Hartford
Partridge, W. P., Harvard '20, West Hartford
Pascal, T. J., Rush '31, Bridgeport
Pasetto, E., Vermont '36, Waterbury
Pasquariello, D. W., Naples '36, Bridgeport
Pasternak, M., Toronto '36, New Haven
Patterson, F. A., Harvard '27, Norwalk
Patterson, H. C., Bowman Gray '45, Danbury
Paul, F., Munich '24, Norwalk
Paul, J. R., Johns Hopkins '19, New Haven
Paul, V. A., Hahnemann, Chicago '13, Stamford
Peacock, A. U., Rush, '33, Hartford
Pearce, M. G., Texas '22, New Canaan
Pease, M. C., Columbia '06, Ridgefield
Peck, B. C., Long Island '31, New Britain
Peck, D. R., Yale '43, New Haven
Peck, R. E., Yale '93, Concord, New Hampshire (New Haven County)
Peckham C. H., Johns Hopkins '23, Manchester
Pellens, M., Cornell '30, Bridgeport
Pelliccia, O., Jr., Johns Hopkins '39, New Haven
Pelz, K., Vienna '32, Wallingford
Pendleton, E. R., P. & S., Boston '04, Westfield, Mass. (Hartford County)
Penner, S. L., Columbia '34, Stratford

Pennington, H. F., Harvard '27, Meriden
Pepe, A. J., Maryland '35, Norwich
Pepper, D. S., Pennsylvania '32, Hartford
Perakos, G. P., Georgetown '32, New Britain
Perham, W. S., Michigan '32, New Haven
Perkins, C. W., Hahnemann '01, Norwalk
Perkins, J. A., McGill '41, Hartford
Perreault, J. N., Tufts '07, Danielson
Perry, D. D., N. Y. Med. Coll. '45, Bristol
Peters, J. P., Columbia '13, New Haven
Peterson, C. K., Tufts '05, Lakeville
Peterson, E. B., Vermont '28, Norwich
Petrelli, J., Yale '25, New Haven
Petrillo, C., Yale '38, New Haven
Pfeiffer, P. H., Harvard '43, Danbury
Pharris, C., Tennessee '29, Glastonbury
Phelps, M. O., McGill '29, Hartford
Phelps, P. S., McGill '30, Collinsville
Philipson, S., N. Y. Homeo. '18, New Haven
Phillips, F. L., Yale '06, New Haven
Phillips, H. S., Toronto '22, Westport
Phillips, K. T., Tufts '19, Putnam
Phillips, N. T., Boston '44, Waterbury (New London County)
Piacente, S. S., Rochester '40, Hartford
Piasecki, J. L., Maryland '12, Norwalk
Piasta, P. F., Boston '24, Middletown
Piazza, G. J., Boston '32, New Haven
Piccolo, P. A., Maryland '37, New Haven
Pickren, T. R., Arkansas '44, Bridgeport
Pierce, H. F., Johns Hopkins '35, Hartford
Pierson, E. M., Yale '24, Cromwell
Pierson, L. A., Tufts '27, Meriden
Pike, E. R., Michigan '98, East Woodstock
Pike, M. M., Harvard '25, Hartford
Pileggi, P., Maryland '28, Bridgeport
Pils, A. R. Amsterdam '38, New London
Pinn, A. S., Laval '29, New Haven
Pious, W. L., Jefferson '32, New Haven
Pitegoff, C. H., St. Louis '40, New Haven
Pitegoff, G. I., St. Louis '37, Hartford
Pitock, M. P., Tufts '30, Bridgeport
Pizzo, P. S., N. Y. U. '45, Hartford
Plachta, A., Warsaw '30, New York City (Hartford County)
Platt, I. S., Southern California '12, Waterbury
Platt, W. L., Columbia '81, Newtown (Litchfield County)
Platz, E. J., Pennsylvania '43, Manchester
Plukas, J. M., Georgetown '32, Bridgeport
Plunkett, J. P., Chicago '43, New Haven
Poczabut, J. S., Vermont '41, Stamford
Poirier, T. M., Georgetown '34, Windsor
Pola, W. E., Louisville '32, New Britain
Polito, F. L., Yale '21, Torrington
Polivy, C., N. Y. U. '42, Hartford
Pollard, R. L., Tufts '36, Waterbury
Pollock, H. M., Jr., Boston '36, Bristol
Pomeroy, N. A., Columbia '96, Waterbury
Pomeroy, W. H., Maryland '43, Poquonock
Pond, M. J., Rush '15, Kirksville, Mo. (Hartford County)
Poole, A. K., Johns Hopkins '23, New Haven
Popkin, M. S., George Washington '35, Bridgeport
Porter, E. C., Harvard '45, Hartford
Post, E. A., Georgetown '33, Upper Darby, Pa. (New Haven County)
Poverman, D., Vermont '32, New Haven
Powell, W., Queen's '24, New Haven
Powers, G. F., Johns Hopkins '13, New Haven
Pratt, A. P., Harvard '22, Windsor
Pratt, G. K., Detroit '15, Bridgeport
Pratt, N. T., Yale '04, Old Saybrook (Fairfield County)
Prescod, H. J., Howard '50, Middletown
Prestley, W. F., Harvard '40, Hartford
Preston, T. R., Yale '25, West Hartford
Priddy, F. E., Northwestern '28, Hartford
Prignano, J. V., Georgetown '40, Manchester
Prosser, F. D., Cornell '28, Putnam
Prout, E. B., Syracuse '14, Hartford (Middlesex County)
Pulaski, J. E., Georgetown '44, Hartford
Pullen, R. W., Yale '21, New York (Hartford County)
Purinton, C. O., Yale '00, New Hartford (Hartford County)
Purnell, M. A., Boston '49, Rockville
Purney, J., Jr., McGill '39, Bristol
Pyle, E., Columbia '15, Waterbury
Pyrtek, L. J., Rush '42, Hartford

Quarrier, S. S., Columbia '32, Hartford
Quatrano, J. C., Vermont '31, Bridgeport
Quinlan, R. V., P. & S., Balt. '10, Meriden
Quinn, J. F., Maryland '06, Bridgeport
Quinn, K. S., Temple '35, Bridgeport
Quinn, R. J., P. & S., Balt. '13, Waterbury
Quintiliani, A., Harvard '29, Norwich

Rabinovitch, Alec, Vermont '21, Norwich
Rademacher, E. S., Iowa '23, New Haven
Radin, M. J., Columbia '16, Hartford
Radom, M. M., Jefferson '25, Hartford
Radowiecki, M. W., N. Y. Med. '43, New Haven
Raffa, J., Columbia '34, Glastonbury
Raffaele, F. J., W. Ontario '30, Stamford
Rafferty, B., Jefferson '28, Willimantic
Rafkind, A. B., Paris '37, Middletown
Ralston, R. M., Johns Hopkins '44, Brookfield Center
Rand, P. K., Jr., Tulane '40, Hartford
Rand, R. F., Johns Hopkins '00, Hamden
Randolph, M. F., Rochester '43, Danbury
Ranger, C. O., Montreal '25, Norwich
Rankin, B. F., McGill '19, Hartford
Rankin, C., Nebraska '43, Hartford
Rasmussen, H. N., Tufts '25, Uncasville
Ravitz, L. J., Wayne '46, Shaker Heights, Ohio (New Haven County)
Rawls, E. C., Med. Coll. Va. '31, Stamford
Rayl, D. F., Johns Hopkins '43, Bridgeport
Raymer, J. G., Harvard '25, Norwich
Read, F. A., Yale '34, Old Greenwich
Reade, E. G., Jefferson '16, Watertown
Reardon, W. F., P. & S., Balt. '04, Hartford
Redlich, E. A., Vienna '35, New Haven
Redlich, F. C., Vienna '35, New Haven
Reed, J. F., Cornell '41, Hartford
Reich, U. S., Virginia '09, Bridgeport
Reichenbach, A. E., Tufts '38, Waterbury
Reidy, D. D., Columbia '27, Hartford
Reidy, M. J., Jr., St. Louis '42, Winsted
Reilly, W. J., Tufts '35, Naugatuck
Reiter, B. R., Harvard '34, Bridgeport
Rem, E. A., Long Island '47, South Norwalk
Renehan, J. M., Tufts '28, Ansonia
Rentsch, S. B., Michigan '23, Derby
Resnik, E., McGill '30, New Britain
Resnik, H., Johns Hopkins '31, Bridgeport
Resnik, W. H., Johns Hopkins '21, Stamford
Reynolds, H. St. C., Yale '10, Hartford
Reynolds, H. S., Albany '14, Hartford
Reynolds, J. A., Tufts '36, Waterbury
Reynolds, W. M., Columbia '31, Greenwich

Ribner, H., Tufts '34, Bridgeport
Ricca, R. A., Pennsylvania '40, Glastonbury
Riccio, F. J., Rome '42, Bridgeport
Riccio, J. S., St. Louis '37, Waterbury
Riccitelli, M. L., Yale '22, New Haven
Richards, W. R., Cornell '35, New Haven
Richardson, R. A., Vermont '14, Bristol
Richman, D. P., N. Y. U. '42, South Norwalk
Riege, D. H., Yale '46, Hartford
Riendeau, F. M., Paris '27, Torrington
Riendeau, P. L., Paris '27, Torrington
Riesmann, J. P., Pennsylvania '38, New Haven
Rilance, A. B., McGill '31, New Haven
Rindge, M. E., Duke '41, Madison
Rindge, M. P., P. & S., Cleveland '05, Madison
Rindge, N. P., Yale '35, Clinton
Riordan, W. D., N. Y. Med. Coll. '43, New Haven
Robb, S. A., Cornell '40, Meriden
Robbins, J., Paris '37, Thompsonville
Roberge, G. E., Yale '38, Stratford
Roberts, B. H., Toronto '44, New Haven
Roberts, D. J., Vermont '16, Hartford
Roberts, E. R., Maine '13, Bridgeport
Roberts, F. W., Johns Hopkins '24, New Haven
Robertson, A. R., Temple '42, Torrington
Robertson, G. F., Columbia '41, Greenwich
Robey, N. C., Yale '17, Newtown
Robinson, A. J., Toronto '23, Hartford
Robinson, B. R., Yale '43, Hartford
Robinson, D., Johns Hopkins '42, Hartford
Robinson, F., Cornell '42, New Haven
Robinson, W. J. T., Long Island '21, Broad Brook
Robison, R. C., Yale '36, Stamford
Roccapriore, B. A., Jefferson '31, Middletown
Rocco, M. P., Georgetown '41, Hartford
Roch, G. E., Tufts '34, Willimantic
Roche, A. F., Georgetown '17, West Hartford
Rockwell, A. E., Johns Hopkins '21, Bridgeport
Rogers, E., Cornell '30, Ridgefield
Rogers, F. P., Syracuse '33, West Hartford
Rogers, J. F., Duke '42, Stamford
Rogers, O. F., Jr., Harvard '12, New Haven
Rogers, P. H., Yale '12, West Haven
Rogers, R. P., Harvard '25, Greenwich
Rogol, L., Long Island '33, Danbury
Rogol, O., Dalhousie '32, Seymour
Rogowski, B. A., Yale '24, New Haven
Roh, C. E., Columbia '41, Hartford
Rollins, H. B., Yale '22, Hartford
Romaine, F. C., Hahnemann '48, Bridgeport
Romaniello, R. J., Columbia '27, Elmwood
Rooney, J. F., P. & S., Balt. '03, Plainville
Root, J. H., Harvard '18, Waterbury
Root, J. H., Jr., Syracuse '43, Waterbury
Root, M. T., Cornell '18, West Hartford
Root, S. A., Cornell '19, West Hartford
Rosahn, P. D., N. Y. U. '28, New Britain
Rose, S. A., N. Y. U. '20, Stamford
Rosen, T., Tufts '33, Manchester
Rosenbaum, G. J., Tufts '34, Hartford
Rosenberg, B. L., McGill '43, Stamford
Rosenberg, H. A., Vienna '37, Bridgeport
Rosenberg, H. A., Yale '30, Waterbury
Rosenberg, S., American Univ. Beirut '39, Bridgeport
Rosenthal, B. B., N. Y. U. '30, Milford
Rosenthal, E., Munich '25, Hartford
Rosenthal, I., Long Island '10, South Norwalk
Rosenthal, R. L., Long Island '38, Branford
Rosner, F., Vienna '37, Bridgeport
Ross, A. M., Basel '35, Darien
Roth, F. E., N. Y. U. '25, Hartford
Roth, O., Vienna '37, New Haven
Roth, S. Z., Vienna '36, New Haven
Rothblatt, R., Harvard '37, Willimantic
Rothschild, M. L., Paris '26, New Haven
Rourke, T. A., Columbia '37, Greenwich
Rousseau, D. G., Vermont '45, Taftville
Rowley, J. C., Harvard '06, West Hartford
Rowley, R. L., Yale '03, Hartford
Rowley, S. D., Jefferson '46, Hartford
Rowson, Walter, Jr., Yale '43, North Grosvernordale
Roy, J. L., Tufts '34, Newtown
Rozen, A. A., Yale '37, New Haven
Rubin, A., Geneva '29, Hartford
Rubin, D., Cambridge '38, South Norwalk
Rubin, G. A., Edinburgh '32, New Haven
Rubinow, M. B., Long Island '42, Manchester
Rubio, M., National Univ. Mexico '42, Hartford
Ruby, M. H., Columbia '21, Waterbury
Ruby, R. J., Baylor '36, Waterbury
Rudnick, C. J., Long Island '17, Bridgeport
Ruiz, R. R., Havana '43, Danbury
Rup, E. C., Georgetown '43, Hartford
Russell, G. G., Harvard '19, Hartford
Russell, T. H., Yale '10, New Haven
Russell, W. I., Yale '09, New Haven
Russman, C., Tufts '23, Middletown
Russo, J. D., Yale '16, New Haven
Russo, J. N., Vermont '45, West Hartford
Russo, J. R., Columbia '43, Bridgeport
Russo, R. D., Georgetown '43, Bridgeport
Ryan, A. J., Columbia '40, Meriden
Ryan, F. J., Tufts '35, Hartford
Ryan, J. J., Columbia '41, Stamford
Ryan, V. G., Yale '34, Portland
Ryan, W. A., McGill '45, Stamford
Ryder, C. F., Western Reserve '33, South Norwalk
Ryder, R. H., P. & S., Balt. '13, Waterbury
Ryder, W. H., Jefferson '20, New Haven
Ryley, R. N., Yale '39, Mystic

Sabia, D. J., Marquette '36, Stamford
Sachs, B., N. Y. U. '37, Hartford
Sachs, E., Johns Hopkins '04, New Haven
Sachs, J. A., Yale '46, New Britain
Sachs, J. J., N. Y. U. '40, Hartford
Sachs, K., Vienna '35, New Orleans, La. (New Haven County)
Safford, T., Jr., Long Island '47, Ridgefield
Saidel, J. W., Chile '38, Bridgeport
St. John, L. A., Fordham '20, Hartford
St. John, N. E., George Washington '48, Hartford
Salinger, R., Johns Hopkins '25, New Haven
Salter, W. T., Harvard '25, New Haven
Saltzman, J. A., N. Y. Homeo. '33, Waterbury
Salvin, B. L., George Washington '21, Hartford
Samponaro, N., Johns Hopkins '29, Torrington
Samson, D. P., Columbia '43, Thomaston
Sanderson, R. V., Vermont '20, Winsted
Sandulli, G. R., Tufts '29, Waterbury
Santiccioli, A. B., Bologna '40, Middletown
Santoro, G. M., Cornell '24, Waterbury
Saposnik, J. J., Howard '33, West Haven
Satti, C. J., Yale '23, New London
Saunders, G. R., Cornell '41, Old Saybrook
Savak, J. E., Boston '45, Springdale
Savin, S., Vermont '45, Bridgeport
Sayers, D. O'C., Tufts '35, Waterbury

Sayers, J. J., Tufts '35, Hartford
Scafarello, P. J., Tufts '26, Hartford
Scalzi, L. C., Bologna '37, Bridgeport
Scanlon, J. J., Georgetown '35, South Norwalk
Scanlon, T. F., Yale '07, Norwalk
Scanlon, W. G., Long Island '41, New Canaan
Scarbrough, M. McR., Yale '07, New Haven
Schaefer, A. M., Yale '25, Hartford
Schaefer, J., Tufts '17, East Hartford
Schardt, W. M., N. Y. U. '45, Manchester
Schatten, S. S., N. Y. U. '31, West Hartford
Schechtman, C. T., Vermont '26, New Britain
Schenck, Kenneth, Columbia '34, Storrs (Windham County)
Schiavetti, A., Tufts '30, Stafford Springs
Schloss, G. T., Berlin '37, Grand Rapids, Michigan (New London County)
Schloss, W. A., N. Y. U. '40, Hartford
Schmidt, N. L., Vanderbilt '27, Stamford
Schmidt, W. F., Stanford '50, Darien
Schnap, I., Long Island '29, Hartford
Schneider, W., George Washington '30, Rockville
Scholhamer, C. F., Yale '42, New Haven
Scholl, R. F., Yale '12, New Haven
Schopick, L. E., Zurich '35, Bridgeport
Schupack, S. D., Tufts '24, New Britain
Schultz, M., N. Y. U. '43, Westport
Schwartz, H. N., Med. Coll. of Va. '37, Hartford
Schwartz, P. E., Tufts '31, Middletown
Schwarz, H. P., Vienna '38, Norwich
Sciortino, M. V., Naples '37, Bridgeport
Scott, C. R., Yale '19, New Haven
Scoville, W. B., Pennsylvania '32, Hartford
Scully, M. R., Columbia '41, Bridgeport
Scully, R. T., Georgetown '35, New Britain
Seabury, R. B., Harvard '18, New Haven
Sears, L., Harvard '29, Norwich
Segal, J. A., Tufts '28, Manchester
Segel, S., Vermont '35, Norwich
Segnalla, E., Yale '12, New Haven
Seibert, A. F., Yale '27, Hartford
Seideman, R. M., Long Island '36, West Hartford
Seigle, S. P., Harvard '40, Hartford
Sekerak, A. J., Maryland '22, Bridgeport
Sekerak, R. A., Maryland '29, Bridgeport
Sekerak, R. J., Maryland '34, Bridgeport
Selesnick, K. S., Boston '34, Newington
Selleck, N. B., Long Island '24, Danbury
Sellew, R. C., Jr., Long Island '36, Canaan
Senfield, M. M., Vienna '20, Ansonia
Senn, M. J. E., Wisconsin '27, New Haven
Sennett, E. J., Vermont '43, Hartford
Serafin, P. J., N. Y. U. '21, New Haven
Serbin, A. F., Rush '33, Hartford
Serena, F. A., Hahnemann '40, Norwalk
Serena, J. M., Hahnemann '41, South Norwalk
Serrell, H. P., Cornell '32, Greenwich
Sette, A. J., George Washington '27, Stamford
Sewall, S., Maryland '37, Hartford
Shain, J. H., Tufts '28, Homestead, Florida (Fairfield County)
Shapiro, Robert, Pennsylvania '39, New Haven
Shaw, L. E., Wom. Med. Coll. Pa. '22, Greenwich
Shea, C. J., Maryland '33, Bridgeport
Shea, D. E., Loyola '17, Hartford
Shea, J., P. & S., Balt. '11, Bridgeport
Shea, J. P., N. Y. U. '46, Milford
Shea, M. S., Vermont '21, New Haven
Shea, V. T., Tufts '31, Waterbury
Sheard, C., Toronto '39, Stamford
Shearer, J. K., Albany '43, Waterbury
Sheehan, M. T., Yale '10, Wallingford
Sheiman, M., Michigan '39, Bridgeport
Sheiman, S. C., Michigan '40, Bridgeport
Shenker, B. M., N. Y. Med. Coll. '38, Middletown
Shepard, M. D., N. Y. U. '37, Hartford
Shepard, W. M., Columbia '29, Putnam
Shepherd, W. G., Toronto '08, Hazardville
Shermak, J. V., Vienna '19, Old Greenwich
Sherman, B., George Washington '29, Bridgeport
Sherman, H., Johns Hopkins '25, Pleasant Valley
Sherman, I. J., Johns Hopkins '40, Bridgeport
Sherman, S. H., Columbia '34, Stamford
Sherwood, H., N. Y. Med. Coll. '37, Middletown
Sherwood, P. M., Boston '42, Hartford
Shirk, S. M., Hahnemann '97, Wallingford (Fairfield County)
Sholler, N. A., Hahnemann '43, Bridgeport
Shoukimas, J., Harvard '42, Hartford
Shoup, H. B., Jr., Indiana '35, Westport
Shreve, R. W., Cornell '40, West Hartford
Shull, J. C., Harvard '36, Hartford
Shulman, D. N., Johns Hopkins '17, Hartford
Shure, A. L., Tufts '27, New Haven
Shutkin, N. M., Northwestern '37, New Haven
Siege, A. G., N. Y. Med. Coll. '43, APO 843 (N. Y.) Fairfield County)
Sigal, J. B., Yale '23, Hartford
Sigel, H., Tufts '34, New Haven
Silbermann, J. S., Vienna '36, Hartford
Siliciano, R. A. V., Hahnemann '24, Bristol
Silliman, W. B., Jefferson '46, Windsor
Silver, G. B., Tufts '37, Hartford
Silverberg, S. J., Columbia '21, New Haven
Simmel, E. R., Heidelberg '18, Norwich
Simmons, E. M., Yale '23, Southington
Simon, L. G., N. Y. U. '27, South Norwalk
Simonds, J. R., Vermont '38, Washington
Simonton, F. F., Maine '03, Philadlephia, Pa. (Hartford County)
Simses, J. P., Tufts '37, Bridgeport
Sinclair, E. B., Yale '35, Hartford
Sirota, H. H., Cambridge '37, East Hartford
Skiff, S. E., Hahnemann '03, New Haven
Sklaver, J., Michigan '37, Waterbury
Skluth, L. H., N. Y. U. '36, Norwalk
Skorneck, A. B., Minnesota '43, Newington (New Haven County)
Slater, D., N. Y. Med. Coll. '40, Hamden
Slater, G., Vienna '38, Stamford
Slater, M., Yale '24, Hamden
Slavin, J. E., Vermont '12, Waterbury
Slossberg, D. S., Tufts '34, Hartford
Slysz, L. B., Boston '27, New Britain
Small, A. R., N. Y. Med. Coll. '48, Bridgeport
Smilgin, V. E., George Washington '38, New London
Smirnow, M. R., Yale '06, New Haven
Smith, A. C., P. & S., Balt. '10, Danbury
Smith, B. A., Yale '40, Norwich
Smith, C. L., N. Y. U. '41, Hartford
Smith, C. S., Hahnemann '16, New Haven
Smith, D. P., Yale '12, Meriden
Smith, E. J., Columbia '04, Madison
Smith, E. R., Yale '40, Meriden
Smith, E. T., Yale '97, West Hartford
Smith, F. F., Howard '30, New Haven
Smith, F. M., Vermont '11, Willimantic
Smith, H. E., Columbia '15, Middlefield
Smith, J. A., Western Reserve '35, Waterbury
Smith, J. J., Maryland '30, Bridgeport

Smith, J. T., Long Island '41, Winsted
Smith, L. M., Tufts '37, Stamford
Smith, N. N., Yale '24, New Haven
Smith, S. R., Med. Chi. Phila. '16, Bridgeport
Smith, V. J., Pennsylvania '20, New Britain
Smith, V. L., Medical Evangelist '37, Chester
Smith, W. B., Pennsylvania '22, Hartford
Smith, W. F., Cornell '34, Hartford
Smith, W. L., Columbia '37, Hartford
Smolen, E. M., N. Y. U. '44, Fairfield
Smykowski, B. L., P. & S., Balt. '11, Bridgeport
Snavely, J. G., Yale '41, Stamford
Snavely, M. E., Yale '25, West Haven
Sneidman, G. I., Virginia '36, Hartford
Snelling, P. W., Harvard '21, Hartford
Snoke, A. W., Stanford '33, New Haven
Snurkowski, C. V., Georgetown '25, New Haven
Sohler, T. P., Freiburg '35, New Haven
Sokolski, E. J., Maryland '45, Danbury
Sollosy, A., Tufts '27, Bridgeport
Solnit, A. J., California '43, New Haven
Solomkin, M., St. Louis '42, Hartford
Solomon, C. I., Yale '25, Hartford
Solomon, R. Z., Yale '39, Hartford
Soltz, T., Jefferson '11, New London
Solway, R. I., Toronto '40, Westport
Solway, S. A., Toronto '43, Darien
Sommers, M., Yale '36, Stamford
Soreff, L., Tufts '32, East Hampton
Sorokowski, G. W., Vienna '47, East Hartford
Spannaus, F. C., Jr., N. Y. U. '45, Danbury
Spector, N., Tufts '24, Willimantic
Speight, H. E., Georgetown '27, Middletown
Spekter, L., Rochester '33, Hartford
Spencer, L. O., Tulane '26, Milford
Spencer, S., Georgetown '39, Bridgeport
Sperandeo, A., Yale '25, New Haven
Spiegel, C. M., Hahnemann '36, New Haven
Spignesi, J. T., Georgetown '30, Wallingford
Spillane, B., Tufts '16, Hartford
Spillane, R. J., Washington '43, Hartford
Spinelli, N. P. R., Yale '44, Stratford
Spinelli, N. V., Marquette '39, Bridgeport
Spinner, S., Tufts '35, New Haven
Spitz, H., Yale '43, New London
Sponzo, J. J., Tufts '38, Hartford
Sprague, C. H., Columbia '04, Bridgeport
Squillacote, V. J., Rome '34, New Britain
Squillante, O. J., Maryland '40, Barrington, R. I. (Tolland County)
Stahl, W. M., Maryland '14, Danbury
Stahl, W. M., Jr., Harvard '46, Danbury
Stainbrook, E. J., Duke '45, New Haven
Standish, E. M., Harvard '22, Hartford
Standish, F. B., Yale '03, New Haven
Standish, H. C., Cornell '28, West Hartford
Standish, J. H., N. Y. U. '95, Hartford
Standish, W. A., Yale '25, Hartford
Staneslow, J. S., Cornell '26, Waterbury
Stankard, W. F., Jefferson '38, Stamford
Starr, R. M., Yale '26, New London
Starr, R. S., Columbia '01, South Windsor
Starrett, J. E., Tufts '30, Stamford
Staub, J. H., Long Island '99, Stamford
Staub, P. L., Long Island '39, Bridgeport
Steege, T. W., Yale '38, Hartford
Steel, R. M., Boston '46, Stratford
Stein, J. D., Columbia '44, Bridgeport
Steinberger, L., Royal Hungarian Eliz. '37, South Norwalk
Steincrohn, P. J., Maryland '23, Hartford
Steinecke, O., Virginia '25, New London
Stephens, D. C., Wayne '32, Greenwich
Sterrett, R. A., Cornell '39, Southport
Stetson, H. P., Boston '41, Southington
Stetson, H. W., Vermont '06, Milford
Stettbacher, H. J., Harvard '22, Waterbury
Steven, R. J. M., London '43, Hartford
Stevens, H. G., Maryland '04, New Milford
Stevens, J. G., Maryland '41, Bridgeport
Stevens, M. A., Yale '29, New York, N. Y. (New Haven County)
Stevenson, E. V., Jr., Albany '42, Thompson
Stevenson, J. K., Albany '44, Thompson
Stevenson, W. R., Boston '31, New York (Hartford County)
Stewart, L. Q., Yale '33, West Hartford
Stietzel, E. E., Columbia '34, South Norwalk
Stilson, C., Yale '42, New Haven
Stone, E. C., Boston '46, New London
Stone, E. L., Johns Hopkins '20, New Haven
Storer, D. P., Temple '46, Boston, Mass. (Hartford County)
Storms, W. F., Harvard '30, Wethersfield
Storrs, R. W., Harvard '20, Hartford
Strauss, M. J., Columbia '17, New Haven
Strayer, E. M., Columbia '33, Washington, D. C. (Fairfield County)
Strayer, L. M., Jr., Harvard '30, Bridgeport
Street, J. M., Duke '42, New Milford
Stretch, J. E., George Washington '28, Simsbury
Strickland, H., McGill '30, Meriden
Stringfield, O. L., Univ. & Bellevue '16, Stamford
Studenski, E. R., N. Y. U. '43, Hartford
Sturtevant, J. M., Bowdoin '14, New London
Stygar, J. S., St. Louis '33, Derby
Sullivan, A. B., Yale '38, West Hartford
Sullivan, A. F., Jefferson '42, Waterbury
Sullivan, C. N., McGill '30, New Britain
Sullivan, D., Univ. & Bellevue '97, Waterford
Sullivan, J. F., Columbia '94, New Haven
Sullivan, T. J., Yale '17, New Haven
Sulman, M., Columbia '36, New London
Sulzycki, M. M., Georgetown '43, Bridgeport
Sunderland, P. U., N. Y. Homeo. '94, Danbury
Sunderland, W. A., Yale '26, Danbury
Sundquist, A. B., Tufts '33, Manchester
Sunkin, D. F., N. Y. U. '42, Hartford
Suplicki, J. W., Tufts '26, Norwich
Sussler, D., Fordham '16, Norwich
Sutherland, F. A., Harvard '26, Torrington
Suttles, C. M., Jefferson '44, Norwich
Sutton, P., Vienna '36, Groton
Svedlow, B. D., George Washington '41, Stamford
Swan, B. R., Cornell '43, New Haven
Swan, H. C., Tufts '03, Hartford
Swarts, W. B., Pennsylvania '34, Greenwich
Sweet, A. N., Maryland '18, Middletown
Swenson, A. C., Yale '02, Waterbury
Swett, N. P., N. Y. U. '46, Hartford
Swift, W. E., Jr., Columbia '40, New Haven
Swirsky, M. Y., N. Y. Med. Coll. '39, New Haven
Syz, H., Geneva '21, Westport
Szanton, V. L., Duke '36, Ansonia
Szlemko, E. A., Geneva '38, Groton
Szur, R. J., Budapest '43, Bridgeport

Taffel, M., Yale '31, New Haven
Tait, A. A., Illinois '30, Moorhead, Minnesota (Hartford County)
Talbot, H. P., Maryland '27, Hartford

Tanner, W. A., Vermont '12, Danielson
Tarasovic, T. J., Tufts '36, Bridgeport
Tarbell, L. A., Vermont '25, Heightstown, N. J. (New Haven County)
Tate, W. J., Yale '29, Deep River
Taylor, C. C., Harvard '16, Bridgeport
Taylor, H. C., Cornell '38, Meriden
Taylor, M. C., Harvard '29, Norwich
Taylor, R. M., George Washington '22, East Haven
Taylor, R. N., Yale '30, New London
Taylor, S. P., George Washington '16, North Haven
Teahan, J. W., McGill '39, Hartford
Teiger, P., Columbia '39, Waterbury
Tella, R. T., Tufts '45, Stamford
Tennant, R., Yale '29, West Hartford
Terhune, W. B., Tulane '15, New Canaan
terKuile, R. C., Rochester '32, Bridgeport
Terry, J. S., N. Y. Med. Coll. '45, Bridgeport
Teuscher, W. P., Tufts '32, Westport
Thalberg, R. E., Yale '26, Southington
Thau, M., Paris '34, Hartford
Thayer, J. E., Vermont '43, Hartford
Thayer, R. B., Bowdoin '20, Somers
Thayer, R. B., Jr., Yale '46, Hazardville (Tolland County)
Thenebe, C. L., Pennsylvania '18, West Hartford
Thomas, A. H., Duke '42, Manchester
Thomases, S., N. Y. U. '39, Stratford
Thompson, C. G., N. Y. Homeo. '18, Norwich
Thompson, H. G., Harvard '17, Hartford
Thompson, L. E., Boston '25, Meriden
Thompson, S. A., Cornell '23, Greenwich
Thoms, H., Yale '10, New Haven
Thomson, A. W., Jr., Cornell '43, Middletown
Thomson, T. L., Hahnemann '01, Torrington
Thumin, M., Maryland '33, Middletown
Tiebout, H. M., Johns Hopkins '21, Greenwich
Tileston, W., Harvard '99, New Haven
Tillinghast, J. W., Arkansas '44, Norwich
Timm, A. B., Jr., Harvard '40, Milford
Tinkess, D. E., McGill '25, Greenwich
Tirella, F. F., Tufts '37, Bristol
Tisher, P. W., Iowa '35, New Britain
Tokarczyk, J. J., Vermont '20, New Britain
Tolk, N. R., N. Y. U. '20, Bridgeport
Toll, N., Charles Univ., Prague '27, Middletown
Tomaino, F. F., Yale '29, Danbury
Tombari, S. P., Boston '34, Waterford
Tonken, L. C., Tufts '34, Hartford
Tortolani, A. P., McGill '34, Plainville
Tortora, F., Rome '40, New Haven
Tovell, R. M., Queen's '26, Hartford
Tower, A. A., Columbia '19, Meriden
Towne, N. A., Vermont '31, Naugatuck
Townsend, W. C., Harvard '25, Hartford
Tracey, W. W., Columbia '16, Bridgeport
Tracy, F. E., Yale '29, Middletown
Traggis, D. C., Johns Hopkins '42, New London
Trambert, H. L., N. Y. Med. Coll. '42, Norwalk
Trantolo, A., Tufts '39, East Hartford
Trapp, F. W., Georgetown '36, New Britain
Trautman, E. F., Temple '40, Bridgeport
Treat, W. H., Yale '06, Derby
Trent, S. C., Yale '43, Middlefield
Trifari, L. M., Tufts '42, Hamden
Trimpert, A. J., Georgetown '33, Bethel
Troy, W. D., Jefferson '36, Stamford
Truex, E. H., Jr., Harvard '36, Hartford
Tuch, M., Univ. & Bellevue '06, Hartford
Tucker, C. A., Tufts '38, Hartford
Tulin, G. A., Vermont '43, Hartford
Tunick, G. L., Jefferson '35, Greenwich
Turbert, E. J., P. & S., Balt. '04, Hartford
Turchik, F., Jefferson '27, Bridgeport
Turco, V. J., Tufts '41, Hartford
Turcotte, M. R., Jefferson '50, Meriden
Turetsky, S., Baylor '36, Bridgeport
Turkington, C. H., Johns Hopkins '07, Litchfield
Turner, H. G., Jr., Columbia '43, Norwich
Tutles, A. J., Tufts '30, Bridgeport
Twachtman, E., Virginia '36, New Canaan
Twaddle, P. H., Yale '35, Hartford
Tylec, L. L., Virginia '35, Naugatuck
Tynan, J. G., Tufts '42, Waterbury

Unger, M., Hahnemann '37, Bridgeport
Unsworth, A. C., Vermont '31, Hartford
Upham, C. E. H., Pennsylvania '19, Boothbay, Maine (Fairfield County)
Upson, W. H., Tufts '27, Suffield
Uricchio, J. G., Georgetown '31, Hartford
Ursone, F. D., Tufts '29, Norfolk
Uvitsky, I. H., Boston '27, Bridgeport

Vadasz, E., Budapest '29, Meriden
Vail, G. F., Pennsylvania '02, Hartford
Valenski, T. J., Tufts '37, Thompsonville
Van Antwerp, L. D., Michigan '31, Chicago, Illinois (New Haven County)
Van Heuven, J. A., Utrecht '24, New Haven
Van Kleeck, E., Columbia '12, Hartford
Van Leuvan, J. S., Yale '27, Meriden
Van Strander, W. H., Vermont '00, Hartford
Van Tassel, W., N. Y. U. '27, Darien
Van Wart, W. H., Harvard '22, Hartford
Varley, R., Albany '43, New Haven
Vastola, A. P., Fordham '12, Waterbury
Veal, W. T., Jefferson '12, Stonington
Vegliante, M. E., Tufts '27, New Haven
Veneruso, L. C., N. Y. Med. Coll. '42, Bridgeport
Verdi, W. F., Yale '94, New Haven
Veremakis, C., Boston '41, Stamford
Verie, K. E., Tufts '44, New London
Vernlund, C. F., Harvard '14, Hartford
Vernlund, R. J., Vermont '45, Hartford
Vernon, S., Long Island '30, Willimantic (New London County)
Vershbow, N., Tufts '19, West Hartford
Verstandig, C. C., Tennessee '39, New Haven
Vessie, P., Cleveland Pulte '09, New York City (Fairfield County)
Vestal, P. W., Harvard '22, New Haven
Vicas, B., Georgetown '45, Hartford
Vigue, C. E., George Washington '36, Hartford
Vinci, V. J., N. Y. U. '39, Middletown
Vinograd, A., Basle '33, West Haven
Viola, C. P., Tufts '36, Milford
Vioni, R. E., Naples '35, Bridgeport
Vogel, F. S., Vienna '27, Bristol
Vollero, A., Tufts '30, New Haven
Vollmer, J. W., Yale '06, Norwalk
von Glahn, H. D., Duke '42, Old Lyme
Von Salzen, C. F., Columbia '36, Hartford
Voris, J. V. B., Columbia '41, Darien

Wadhams, S. H., Yale '96, Torrington
Wadsworth, R. F., Cornell '19, New Canaan
Wagenheim, H. H., Tulane '43, New Haven
Wagner, E. J., Jefferson '30, Ridgefield

Wagner, H. T., Jr., Indiana '37, New York, N. Y. (New Haven County)
Wakeman, E. T., Yale '22, New Haven
Waldemar-Kertész, J., Vienna '26, New Haven
Walker, D. A., Tufts '38, Rocky Hill
Walker, J. M., Columbia '36, Greenwich
Walker, R., Rochester '37, Hartford
Walker, W. B., Yale '20, Cornwall
Walker, W. H., Harvard '03, Newtown (Hartford County)
Wallace, C. K., Queens '13, Hartford
Wallace, V. G. H., Edinburgh '26, Hartford
Wallach, G. M. K., Berne '39, Torrington
Waltman, I., Yale '41, Hartford
Walton, L. L., Johns Hopkins '33, Hartford
Walzer, E. H., N. Y. U. '40, Bridgeport
Ward, J. P., Georgetown '36, Bridgeport
Wardner, L. H., Cornell '34, Hartford
Warner, C. N., Jr., Tufts '36, Litchfield
Warner, G. H., Yale '97, Bridgeport
Warnshuis, L. C., Edinburgh '11, New London
Warren, H. F., Vanderbilt '15, New London
Warren, H. S., Harvard '36, Wethersfield
Warring, H. L., Howard '28, Hartford
Washburn, W. J., Indiana '21, Stamford
Waskovitz, D., Yale '20, New Britain
Wasserman, E., Yale '45, Bridgeport
Waterman, C., McGill '05, Middletown
Waters, L. L., Yale '37, New Haven
Watson, W. J., N. Y. U. '31, New Britain
Watters, F. B., Temple '44, Hartford
Watts, J. F., Georgetown '12, Bridgeport
Wawro, N. W., Yale '38, Hartford
Way, H. S., Columbia '44, Stamford
Weadon, W. L., Med. Coll. of Va. '05, Bridgeport
Webber, E. R., Jefferson '14, Waterbury
Weber, F. C., Jr., Johns Hopkins '36, Greenwich
Weden, E. A., Jr., N. Y. U. '47, Manchester
Weed, C. A., Harvard '42, Hartford
Weed, F. A., Albany '12, Torrington
Wehger, R. T., Yale '32, Bridgeport
Weidman, W. H., McGill '31, Norwich
Weigel, S. J., Yale '43, Danielson
Weil, A., Univ. & Bellevue '14, New Haven
Weile, F. W., Breslau '22, Naugatuck
Weiner, J., Johns Hopkins '20, New Haven
Weiner, J. G., Yale '29, Hartford
Weiner, S., Columbia '35, Hartford
Weiner, W., Tufts '38, Danbury
Weinstein, N., Trinity (Dublin) '34, South Norwalk
Weise, E. C., Jefferson '20, Bridgeport
Weise, E. C., Jr., Jefferson '47, Bridgeport
Weisenfeld, N., Maryland '28, Hartford
Weissenborn, W., Johns Hopkins '32, Hartford
Welch, W. J., Tufts '42, East Hartford
Welch, W. S., Cornell '41, Torrington
Weld, S. B., Harvard '16, Hartford
Wellington, H. W., Columbia '13, New London
Wells, D. B., Johns Hopkins '12, Hartford
Wells, E. C., Women's Med. Coll. Pa. '12, Hartford
Wells, G. R., Harvard '38, Hartford
Wells, J., Yale '37, West Hartford
Wells, J. B., Yale '40, Hartford
Welt, L. G., Yale '38, New Haven
Wener, W. V., McGill '27, Norwich
Wersebe, F. W., Univ. & Bellevue '98, Washington
Wesoly, A. S., Vermont '37, New Britain
Wessel, M. A., Yale '43, New Haven
Weston, R. A., Jr., Harvard '41, Milford
Wexler, H., Syracuse '31, New Haven
Whalen, E. J., Yale '08, Hartford
Whalley, E. J., Tufts '43, Waterbury
Wheatley, L. F., Tufts '03, Brookfield, Vermont (New Haven County)
Whitcomb, B. B., McGill '35, Hartford
White, B. V., Harvard '34, Hartford
White, E. P., Vermont '37, Hartford
White, H. T., Western Reserve '34, Meriden
White, J. C., Harvard '29, New Britain
White, M. L., Maryland '45, New Haven
White, R. L., Eclectic, Missouri '12, New Canaan
White, R. M., Harvard '39, New Haven
White, W. B., Louisville '12, Stamford
Whiting, H. St. J., McGill '21, Middletown
Whiting, L. C., Md. Coll. Med. '12, New Haven
Whiting, R. C., McGill '24, Hartford
Whittles, L. J., Columbia '21, Glastonbury
Whitty, C. A., Queens '29, Newington
Wiedman, O. G., Pennsylvania '05, Hartford
Wieler, H. J., Columbia '28, Lakeville
Wienski, J. C., Hahnemann '21, West Hartford
Wiepert, W. M., Yale '37, Avon
Wies, C. H., Yale '32, New London
Wies, F. A., Yale '33, New Haven
Wiese, C. A., Jr., Harvard '43, Hartford
Wiesel, B., N. Y. U. '36, Hartford
Wight, W. E., Bowdoin '20, Thomaston
Wilcox, L. M., Tufts '33, Terryville
Wilkinson, A. G., Maryland '36, New Haven
Williams, E. E., Columbia '23, Naugatuck
Williams, F. P. A., N. Y. Med. Coll. '44, Monroe
Williams, M. H., Jr., Yale '47, New Haven
Williams, W. E., Columbia '47, Avon
Willner, O., Vienna '05, New Haven
Wilson, A. C., Toronto '34, Hartford
Wilson, C. C., Yale '28, New Haven
Wilson, D. E., Jefferson '30, New Britain
Wilson, F. E., Vermont '11, New London
Wilson, G. C., Yale '28, Norwich
Wilson, J. A., Jefferson '19, Meriden
Wilson, W. A., Louisville '28, Hartford
Wilson, W. R., Johns Hopkins '25, New Haven
Wineck, M. S., Vermont '15, Hartford
Winer, P., St. Louis '44, New Haven
Winick, N. M., N. Y. U. '43, Hartford
Winternitz, M. C., Johns Hopkins '07, Washington, D. C. (New Haven County)
Winters, H. W., Johns Hopkins '29, Bristol
Winters, J. T., Pennsylvania '31, West Hartford
Winters, S., Baylor '20, New Haven
Wise, R. T., N. Y. Med. Coll. '44, New Britain
Witter, O. R., Columbia '01, West Hartford
Wolfe, L. S., Yale '45, New Milford
Wolfson, D., Boston '33, Bethel
Wolfson, S., Sheffield, England '37, New Britain
Wood, D. R., Tufts '43, Hartford
Wood, F. O., Rush '31, Hartford
Wood, G. W., Cornell '46, Norwich
Woodford, C. N., Louisville '08, Hartford
Woodford, F. B., Yale '24, Ridgefield
Woodruff, J. H., Columbia '43, Hartford
Woodward, H. B., Johns Hopkins '12, Bristol
Woodward, J. C., Columbia '35, New London
Woodworth, J. A., Syracuse '39, Moosup
Wool, J. M., N. Y. Med. Coll. '41, New London
Worthen, T. W., Dartmouth '11, Hartford
Wrang, W. E., Jefferson '19, Middletown
Wray, E. H., Jr., Yale '32, Litchfield
Wright, H. S., Cornell '39, Greenwich

Wright, R. C., Columbia '43, New Britain
Wright, W. W., Harvard '19, Hartford
Wrona, E. A., Hahnemann '43, Stamford
Wulp, G. A., Michigan '30, Hartford
Wurtenberg, W. C., Yale '93, New Haven
Wyatt, H., Berlin '36, Hamden
Wyatt, R. H., Yale '43, Stamford

Yannello, M. H., Columbia '43, New Britain
Yannet, H., Yale '29, Southbury
Yasser, I., Colorado '40, Bridgeport
Yavetz, L. M., N. Y. Med. '45, Waterbury
Yeager, C. F., Hahnemann '33, Bridgeport
Yerbury, C. C., N. Y. Med. Coll. '16, Enfield
Yerbury, E. C., Boston '21, Middletown
Yesner, R., Tufts '41, Newington
Yoburn, M. M., Boston '39, Danbury
Young, H. M., Columbia '43, New Britain
Yu, P. E., Michigan '39, Middletown
Yudkin, A. M., Yale '17, New Haven

Zaff, F., Michigan '37, New Haven
Zaglio, E. R., Columbia '33, Manchester
Zagraniski, R. J., Yale '42, New Haven
Zale, C., Toronto '41, Hamden
Zanes, R. P., Jr., Tufts '44, New Haven
Zariphes, C. A. P., Boston '24, Hartford
Zarkin, O. H., Tufts '37, Hartford
Zaur, I. S., Yale '32, Bridgeport
Zavadier, N., Zurich '18, Bridgeport
Zeldis, N., N. Y. U. '46, Hartford
Zeman, B., Kentucky '08, Hartford
Zeman, M. S., Louisville '36, Hartford
Zerkowitz, F., Graz '22, Waterbury
Ziegra, S. R., Yale '47, Deep River
Zielinski, J. B., Jefferson '34, Bridgeport
Zimmerman, H. M., Yale '27, New York, N. Y. (New Haven County)
Zimmerman, L. W., Kansas '35, Hartford
Zonn, S. I., Tufts '17, Waterbury
Zsiga, E. D., Marquette '38, Bridgeport
Zucker, R., Yale '44, Waterbury
Zwick, F., Vermont '13, New Britain
Zyla, E. J., Wayne '43, Wethersfield

ASSOCIATE MEMBERS

Burr, H. S., New Haven
Crankshaw, C. W., South Windsor
Darling, G. B., New Haven
Fulton, J. F., New Haven
Haggard, H. W., New Haven
Hamilton, J. A., Minneapolis, Minn.
Hiscock, I. V., New Haven
Long, C. N. H., New Haven
Mickle, F. L., Hartford
Mooney, Grace, New Haven
Schneider, E. C., Middletown

APR 9 - 1954

APR 9 - 1954

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco Medical Center
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

AUG 25 1966

INTERLIBRARY LOAN
7 DAYS AFTER RECEIPT
CU-Berkeley

PT

10m-5,'65(F3895s4)4315

89376